

Flaum Eye Institute Neuro-Ophthalmology Referral Form

To ensure timely review of your referral please complete this form and fax to 585-320-1078:

Patient Name: _____

Patient DOB: _____

Referring Provider: _____

Referring Provider Phone: _____ Fax: _____

1. Suspected neuro-ophthalmologic diagnosis:

2. Symptoms and duration of symptoms:

3. Prior neuroimaging results (if performed, where & when):

4. Prior visual field testing (if performed, where & when):

5. Prior OCT RNFL results (if performed, where & when):

6. Date of last evaluation by referring provider:

7. Last Routine Eye Exam/Provider Name/Date:

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**University
of Rochester
Medicine**