EYE PLASTIC & FACIAL RECONSTRUCTIVE SURGERY REFERRAL FORM

Dr. Adam S. Hassan & Dr. Jasmina Bajric

TO SIMPLIFY AND STREAMLINE THE REFERRAL PROCESS PLEASE COMPLETE THE FORM IN IT'S ENTIRETY

Date: _____

Patient Name: _____DOB: _____

ADDRESS: _____

_____

Home: ____-____-_____ Work____-_____-_____ Cell ____-____-_____

PRIMARY MEDICAL INSURANCE CARRIER: _____

ID NUMBER: _____

SECONDARY POLICY IF APPLICABLE: _____

- Workman's Comp: YES / NO
- Auto Insurance: YES / NO

  Claim Adjuster: _____ Date of Injury: _____

  Claim #: _____

  Address: _____

  Phone Number: _____

REASON FOR REFERRAL:

○ **Orbital** ○ **Orbital Fracture** ○ **Graves Disease** ○ **Lid Eval** ○ **BCC** ○ **SCC**

OTHER: _____

PLEASE INCLUDE ANY RELEVANT CLINICAL NOTES, SCANS, LABS, OR VISUAL FIELD TESTING

☐ URGENT ☐ 7-14 DAYS ☐ NEXT AVAILABLE

Office Contact: _____ Fax: _____

Referring Physician: _____ Phone: _____

PCP Name: _____ Phone: _____

PCP Address: _____ Fax: _____