WRIGHT VISION CENTER

240 Minnesota St, Rapid City, SD 57701
Phone (605) 718-5123
Fax (605) 646-2020

FAX REFERRAL FORM
605-646-2020

Referring Optometrist_____ UPIN#_____

Referring Optometrist's Phone # ( ) _____-_____

Circle One: Paul Wright, M.D. Colin Brown, M.D.

Cris Mathews, PA Terry Wolthuis, OD Lauren Albers, CNP

Reason for Referral_____

Patient's Name_____

Patient's Date of Birth_____

Patient's Phone # Home: ( ) _____-_____

Cell: ( ) _____-_____

Patient's Email Address_____

Has an appointment been made for the patient?

If yes, date of appointment:_____

If no, should we contact the patient to schedule an appointment? Yes No

Ocular History_____

_____

_____

OD:_____ _____X_____=20/ IOP: OD_____

OS:_____ _____X_____=20/ IOP: OS_____

Additional Comments_____

_____

_____ _____

Signature, Referring Optometrist Date