

### Patient Referral Form for Physicians

**Ph (817) 856-6800**  
**Fx (817) 865-6790**  
**www.retinacentertx.com**

**Jawad Qureshi, M.D.**  
**Johnathan Warminski, M.D.**  
**Musa Abdelaziz, M.D.**  
**Luv Patel, M.D.**

**Southlake**  
305 Morrison Park Drive, Suite #100  
Southlake, TX 76092

**Fort Worth**  
3455 Locke Avenue, #310  
Fort Worth, TX 76107

**Plano**  
3804 15th Street, Suite #130  
Plano, TX 75075

**Dallas**  
12222 N Central Expressway, Suite 250  
Dallas, TX 75243

#### Provider Information

Referring Physician \_\_\_\_\_ Practice \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

#### Patient Information

Patient Name \_\_\_\_\_ Address \_\_\_\_\_

DOB \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

#### What is your patient being referred for?

- Age-Related Macular Degeneration
- Diabetic Retinopathy
- Retinal Vascular Occlusions
- Flashes and Floaters
- Retinal Tear and Retinal Detachment
- Macular Pucker/Epiretinal Membrane
- Macular Hole
- Vitreomacular Traction
- Uveitis
- Other (list) \_\_\_\_\_

#### How soon does your patient need to be seen?

Within \_\_\_\_\_ Days

Within \_\_\_\_\_ Weeks

#### Who are your referring your patient to?

- Jawad Qureshi, MD
- Johnathan Warminski, MD
- Musa Abdelaziz, MD
- Luv Patel, MD
- First Available

Any additional comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please email the completed form to [info@retinacentertx.com](mailto:info@retinacentertx.com) or fax it to (817) 865-6790**