RETINA CENTER OF TEXAS™

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Jawad Qureshi, M.D.
Johnathan Warminski, M.D.
Musa Abdelaziz, M.D.
Luv Patel, M.D.
Margaret Runner, M.D.
M. Zia Siddiqui, M.D.
Omar M. Moinuddin, M.D.

Patient Referral Form for Physicians

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

Plano 3804 W. 15th Street, Suite #130, Plano, TX 75075

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

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

Flower Mound 4951 Long Prairie Road, Suite #130, Flower Mound, TX 75028

Rockwall 1005 W. Ralph Hall Parkway, Suite #145, Rockwall, TX 75032

Alliance 10900 Founders Way, Suite #200, Fort Worth 76244

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 you referring your patient to??

- ☐ Jawad Qureshi, M.D.
- ☐ Johnathan Warminski, M.D.
- ☐ Musa Abdelaziz, M.D.
- ☐ Luv Patel, M.D.
- ☐ Margaret Runner, M.D.
- ☐ M. Zia Siddiqui, M.D.
- ☐ Omar M. Moinuddin, M.D.
- ☐ First Available

Any additional comments _____

_____

_____

Physician Signature _____ **Date** _____

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