

Ophthalmology Referral

Dr. Joseph Neilitz

878 W Airport Rd Menasha

1855 S. Koeller Street, Oshkosh

Referring Doctor: _____ Location: _____

Patient: _____ Patient DOB: _____

Patient Address: _____

Patient insurance: _____

Patient Home Phone: _____ Patient Secondary Phone: _____

Would you like our office to contact the patient to schedule an appointment? Yes No

E11.319 Diabetic Retinopathy

H35.31 Macular Degeneration – Dry

H25.13 Cataract

H35.32 Macular Degeneration – Wet

H40.11X0 Glaucoma

H02.9 Eyelid Lesion

H02.30 Blepharochalasis

H33.309 Suspected Retinal Tear or Hole

H02.109 Ectropion

H26.499 Posterior Capsular Opacification

H02.009 Entropion

H50.9 Strabismus

Other _____

Do you need more referral materials? Yes No

Special Instructions: _____

The office will contact the patient within 24 hours of receiving the referral. Please fax any additional relevant testing along with this form to 920.806.3004