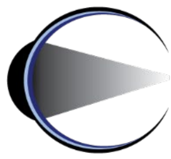

NORTHERN CALIFORNIA
RETINA VITREOUS ASSOCIATES
ESTABLISHED IN 1983

# Patient Referral Form- Please Fax to Preferred Location

***Physicians***

*Mark R. Wieland, M.D.*
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*Rahul Khurana, M.D.*
*Alok S. Bansal, M.D.*
*Louis K. Chang, M.D. Ph.D.*
*Avni P. Finn, M.D.*

***Locations***

**Mountain View**
2495 Hospital Drive
Suite 545
Mountain View, CA 94040
(P): 650-963-3460
(F): 650-963-3480

**San Mateo**
50 S. San Mateo Drive
Suite 125
San Mateo, CA 94401
(P): 650-340-0111
(F): 650-340-9689

**West SJ - Good Samaritan**
2512 Samaritan Court
Suite P
San Jose, CA 95124
(P) 408-356-8818
(F) 408-356-8849

**East SJ - San Jose**
200 Jose Figueres Ave
Suite 415
San Jose, CA 95116
(P) 408-251-3500
(F) 408-251-3535

**Monterey**
798 Cass Street
Suite 200
Monterey, CA 93940
(P) 831-373-6280
(F) 831-373-0151

**Daly City**
901 Campus Drive
Suite 215
Daly City, CA 94015
(P) 650-994-2100
(F) 650-994-2121

Doctor Requesting Consult ____________________ Patient Name______________________________________
Patient Address______________________________ Patient Phone ____________________________________
(Home/Cell) (Work)

Patient Primary Insurance ____________________________ Secondary________________________________
☐ Medicare Advantage ☐ HMO ☐ PPO ☐ Other

NCRVA Doctor Referred To ☐ First Available ☐ Specific Doctor Requested: __________________

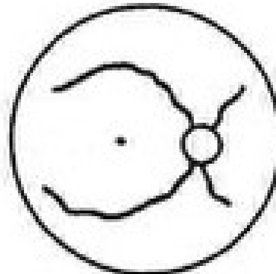
Visual Acuity: R.E. 20/__________L.E. 20/__________

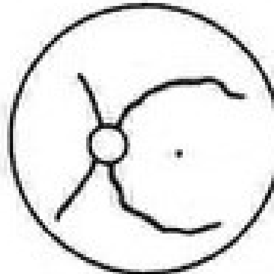
Appt to be scheduled: ___ Immediately (Please Call Office) ___ Within 1 week ___ Within 1 month ___ Patient Preference

**Requesting Office: Please Fax Referral Form to preferred NCRVA location. If emergency/urgent, please call NCRVA location.**

## Fundus Area of Interest

OD





OS

**Consultation for:**__________________________________ (*or check a box*)

☐ Wet AMD or CNV (L/R)_______
☐ Dry AMD (L/R)______
☐ Epiretinal Membrane (L/R)_______
☐ Diabetic Retinopathy (L/R) _______
☐ Macular Edema (L/R) ______
☐ Other Macular Edema (L/R) _____
☐ PVD/Flashes/Floaters (L/R) _____
☐ Retinal Tear (L/R)_____
☐ Retinal Detachment (L/R)_____
☐ Retinal Lesion (L/R)_____
☐ Retinal Vein Occlusion (L/R) _____
☐ Uveitis/Iritis (L/R)____

**Diagnostic Testing Only**

☐ OCT - Macula ☐ OCT- RNFL ☐ B-Scan

***Patient:*** **Please let us know when you are making the appointment if you need a translator during your appointment. Please bring this form with you to your appointment and complete your new patient packet at [www.ncrva.com](http://www.ncrva.com) before your appointment. Also visit ww.ncrva.com for driving directions, maps, information about your doctor and about our current research studies. We look forward to seeing you!**