MARYLAND RETINA INSTITUTE

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Patient Name:_____

Phone Number:_____DOB:_____

Referring Doctor:_____Office Number:_____

Referring Reason:

- ☐ Diabetic Retinopathy
- ☐ Dry/Wet Macular Degeneration
- ☐ Retinal Tear/Detachment
- ☐ Epiretinal Membrane
- ☐ Macular Hole
- ☐ Vitreomacular Traction
- ☐ Retinal Artery/Vein Occlusion
- ☐ Flashes/Floaters
- ☐ Glaucoma Evaluation
- ☐ Vitreous Hemorrhage
- ☐ Cataract Clearance
- ☐ Neuro-Ophthalmology
- ☐ Medication Clearance /Toxicity (ie. Plaquenil, Tamoxifen, etc)
- ☐ Uveitis
- ☐ Other:_____

Thank you for allowing us to participate in the care of your patients.

PLEASE FAX TO 240-483-4493

Raza M. Shah, M.D.