MARYLAND RETINA INSTITUTE

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Patient Name:_____

Phone Number:_____DOB:_____

Referring Provider:_____Office Number:_____

Referring Reason:

- ☐ Annual Exam
- ☐ Diabetes
- ☐ Macular Degeneration
- ☐ Stroke
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Coagulopathy
- ☐ Anemia
- ☐ Blurry Vision
- ☐ Conjunctivitis
- ☐ Light Sensitivity
- ☐ Eye Pain
- ☐ Curtains/Shadows
- ☐ Flashes/Floaters
- ☐ Trauma
- ☐ 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.