**Referral Note to Children’s Eye Care of Connecticut**

**PLEASE FAX THIS NOTE ALONG WITH PATIENT DEMOGRAPHICS TO US AT: 860-359-2540**

Date:

I am referring my patient named \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to you. The patient’s phone number is \_\_\_\_\_\_\_\_\_\_.

The appointment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Will be made by the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Will be scheduled by my office.

Reason for referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Input needed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This referral is:

Emergency

Urgent (24-48 hours)

Timely (1-2 weeks)

When convenient

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If questions or concerns please contact our office at: 860-453-2540