Referral Request

EMG Care Coordination Team
53 Sewall Street | Portland, ME 04102
T: 207.828.2020 ext. 4000 | F: 207.810.3800

Today's Date:

****Please attach most recent office visit note****

Fax Number:		Phone Number:
Referral Requested by:		
EMG Provider (if one preferred):		
Reason for Referral:		**Cataract Referrals only:** ❑Co-Management (CM) Billing requested __Yes __No ❑Signed Post Op Care Request Form ___ Yes ___ n/a
Appointment: ❑Urgent ❑Within 2 weeks ❑Within 1 month ❑Next Available		
❑Most recent visual field test included ❑Most recent OCT included		
Patients Name:		**Date of Birth:**
Patient Information *(or send a patient demographics sheet)*		
Patient's Primary Care Physician:		
Patient's Address:		
City:	State:	Zip Code:
Home Phone:	Mobile:	Patients Email:
Insurance:		Policy# *(or send a copy of the insurance card)*
Contact (if other than patient):		Phone:
Patient Special Needs (ex: interpreter needs, hearing impaired):		