Eyecare Medical Group

Referral Request

53 Sewall Street | Portland, ME 04102
T: 207.828.2020 ext. 4000 | F: 207.810.3811

Today's Date:

Referral Requested by:	Fax Number:
Referral Contact:	Phone Number:
EMG Provider/Location Requested:	
Reason for Referral:	
Appointment: ❑Urgent ❑Within 2 weeks ❑Within 1 month ❑Next Available	
Clinical info included: ❑Most recent office visit note ❑Refraction Info ❑Most recent visual field test ❑Other:	
Comments:	

Patient Information
(or send a patient demographics sheet)

Patient Name:		Date of Birth:
Address:		
City:	State:	Zip Code:
Home Phone:	Work:	Mobile:
Insurance:		Policy# *(or send a copy of the insurance card)*
Contact (if other than patient):		Phone:
Patient Special Needs (ex: interpreter needs, hearing impaired):		

Referring Office Fax: _____

Patient appointment details will be provided

Thank You!

EMG Care Coordination Team

Appointment Date:	Time:
Provider:	
Patient Not Scheduled (Please explain):	