TRIAD PEDIATRIC EYE PHYSICIANS

Referral Form
Fax to (336) 293-4857
Phone: (336) 245-8320
2554 Lewisville-Clemmons Rd, suite 308
Clemmons, NC 27012

Date: _____

Patient name: _____ DOB: _____

Phone (home):_____ (cell):_____ (work):_____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian name: _____ DOB: _____

Email: _____

Pharmacy: _____

PRIMARY INSURANCE: _____

Subscriber ID:_____ Group #: _____

Subscriber Name: _____ DOB: _____

SECONDARY INSURANCE: _____ Group#: _____

Referring Provider: _____ GROUP NPI#_____

Reason for Referral (description and ICD10 code): _____

_____

*Please attach pt. demographics and last clinic note pertaining to referral.

☐ Urgent ☐ Next available

TPEP Office Use Only

SCHEDULED:_____ **TIME:** _____

Checklist:

_____ Enter info into Health Fusion/Meditouch

_____ Invite to Portal /do paperwork within portal 100%

_____ Send Welcome Email

_____ Get Referral/ Auth.

_____ Inform referring office

Contact Attempts:

1. Date:_____/_____/____ at _____ am / pm
   Phone #: Type of Contact:
   (____)_____-_____ _____
   (____)_____-_____ _____
2. Date:_____/_____/____ at _____ am / pm
   Phone #: Type of Contact:
   (____)_____-_____ _____
   (____)_____-_____ _____
3. Date:_____/_____/____ at _____ am / pm
   Phone #: Type of Contact:
   (____)_____-_____ _____
   (____)_____-_____ _____