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Musa Abdelaziz, M.D.	Omar M. Moinuddin, M.D.
Luv Patel, M.D.	

Patient Referral Form for Physicians

Southlake 305 Morrison Park Drive, Suite #100, Southlake, TX 76092

Plano 3804 W. 15th Street, Suite #130, Plano, TX 75075

Southlake 305 Morrison Park Drive, Suite #100, Southlake, TX 76092

Dallas 12222 N. Central Expressway, Suite 250, Dallas, TX 75243

Flower Mound 4951 Long Prairie Road, Suite #130, Flower Mound, TX 75028

Rockwall 1005 W. Ralph Hall Parkway, Suite #145, Rockwall, TX 75032

Alliance 10900 Founders Way, Suite #200, Fort Worth, TX 76244

Burleson 2780 SW Wilshire Boulevard, Burleson, TX 76028

Provider Information

Referring Physician _____ Practice _____

Address _____

Phone _____ Fax _____ Email _____

Patient Information

Patient Name _____ Address _____

DOB _____ Phone _____ Email _____

What is your patient being referred for?

- ☐ Age-Related Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Retinal Vascular Occlusions
- ☐ Flashes and Floaters
- ☐ Retinal Tear and Retinal Detachment
- ☐ Macular Pucker/Epiretinal Membrane
- ☐ Macular Hole
- ☐ Vitreomacular Traction
- ☐ Uveitis
- ☐ Other (list) _____

How soon does your patient need to be seen?

- ☐ Within _____ Days
- ☐ Within _____ Weeks

Who are you referring your patient to??

- | | |
|--|--|
| ☐ Jawad Qureshi, M.D. | ☐ Margaret Runner, M.D. |
| ☐ Johnathan Warminski, M.D. | ☐ M. Zia Siddiqui, M.D. |
| ☐ Musa Abdelaziz, M.D. | ☐ Omar M. Moinuddin, M.D. |
| ☐ Luv Patel, M.D. | ☐ First Available |

Any additional comments _____

Physician Signature _____ Date _____

Please email the completed form to info@retinacentertx.com or fax it to (817) 865-6790