

**North Valley Eye Care**

**1700 Bruce Rd.  
Chico, California 95928**

**Phone: (530) 891-1900  
Fax: (530) 895-1531**

**Prior Referral Request Form**

To PCP/Facility: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ Fax#: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Anticipated Appt. Date: \_\_\_\_\_ with Dr. \_\_\_\_\_

The above patient carries an insurance that may need a prior referral or authorization as they may be enrolled in a managed care plan. The necessary referral or authorization is needed before our ophthalmologist is able to see them for this visit.

Along with a complete annual eye exam and refractive error checks, our ophthalmology services may also include various eye testing and examination services when patient may show such indications of:

Diabetic Retinopathy	Strabismus	Pterygium
Retinopathy of Prematurity	Dermatochalasis	Herpetic Eye Infection
Cataracts	Eye Pain	Retinal Detachment
Glaucoma	Corneal Scar or Ulcer	Age Related Macular Degeneration
Amblyopia	Foreign Body in Cornea	
Nystagmus	Dry Eye Syndrome	

**Examples of possible additional testing may include:**

- Dilated Fundus Exam
- External Photography
- Topography
- Fundus Photography
- Ocular coherence Tomography (OCT)
- Ultrasonography A-Scan/ B-Scan
- Visual Field Examination
- Sensorimotor Exam

\_\_\_\_\_  
Referring Physician Signature

\_\_\_\_\_  
Referring Physician NPI #

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