NEW MEXICO COMMISSION FOR THE BLIND
EMERGENCY EYE CARE PROGRAM
Fax to (505) 272-6125

EMERGENCY EYE CARE PROGRAM REFERRAL LETTER

Date: _____

To whom it may concern:

Referring Physician (Printed): _____

Patient Name: _____

DOB: _____ / _____ / _____

MR#: _____

This patient was seen in our office on _____ / 20_____

Visual acuity measured _____ / _____ OD and _____ / _____ OS.

Examination revealed a diagnosis of

_____

_____

_____

We feel that this is a sight threatening condition which needs to be treated within _____ (hour(s), day(s), week(s), month)

The recommended procedure (INCLUDE CPT CODE) for this patient is:

1. _____
2. _____

The procedure will be done at our Office or Hospital _____

Dr. _____ will perform the procedure and accept the RBRVS Reimbursement rate for the primary procedure as our professional fee.

Referring Physician Signature:_____
Date