

Referral Form – Retinal Rejuvenation Program

Will Vision Center for Retinal Rejuvenation

Photobiomodulation (PBM) Therapy for Early & Intermediate Dry AMD

Referring Provider Information

Practice Name:		Referring Doctor:	
Phone:		Fax:	
Email:		City / State:	

Patient Information

Patient Name:		DOB:	
Phone:		Email:	
Primary Eye(s):	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	Best VA:	

Clinical Information (check all that apply)

<input type="checkbox"/> Early Dry AMD	<input type="checkbox"/> Intermediate Dry AMD	<input type="checkbox"/> AREDS recommended
<input type="checkbox"/> Geographic Atrophy (non-exudative)	<input type="checkbox"/> No CNV history	<input type="checkbox"/> Prior retinal imaging available

Additional Notes / Reason for Referral

How to Refer: Fax or email this form with relevant OCT/fundus images.
Phone: 360-885-1327 Fax: 360-326-2258 Email: cclearly@willvision.com
Will Vision Center for Retinal Rejuvenation will evaluate candidacy and return findings to the referring provider.