Ron W. Pelton M.D., Ph.D., F.A.C.S.
Oculo-Facial Cosmetic & Reconstructive Surgery

FAX REFERRAL FORM

DATE:_____

FAX BACK TO MELITTA @ 719-329-0080

OFFICE: 719-329-0040

PATIENT NAME: _____ DOB: _____

INSURANCE: _____

REFERRAL/AUTHORIZATION: _____

REFERRING PHYSICIAN: _____ PHONE: _____

THE PATIENT ALREADY HAS AN APPOINTMENT WITH YOU ON:

SCHEDULED APPOINTMENT:

- ☐ EMERGENTLY (TO BE SEEN TODAY)
- ☐ URGENTLY (TO BE SEEN THIS WEEK)
- ☐ NEXT AVAILABLE
- ☐ PATIENT WILL CALL FOR APPOINTMENT

PLEASE CALL THE PATIENT TO SCHEDULE AN APPOINTMENT AT:

- ☐ HOME# _____ WORK# _____

REASON FOR CONSULTATION DIAGNOSIS: