SISKIYOU EYE CENTER

Physicians, Surgeons
and Doctors of Optometry

REFERRAL FORM

William S. Epstein, MD
Robert H. Ewing, MD
Jeffrey D. Welder, MD
Jared S. Fredrickson, MD
David S. England, OD

Fax completed form to Siskiyou Eye Center
Ashland: (541) 488-5081
Yreka: (530) 842-5839

DATE: ____________________

REFERRING TO: (Please indicate)

☐ Siskiyou Eye Ophthalmologist *(next available)* ☐ William Epstein, MD ☐ Robert Ewing, MD
☐ Jefferey Welder, MD ☐ Jared Fredrickson, MD ☐ David England, OD

REFERRING DOCTOR: _______________________________

PATIENT: Last Name: ___________________________ First Name: _______________________ MI: ________

Address: ____

Phone Number: (______)______________________ Date of Birth: ____________________________

Abnormalities: OD _____________________________ OS ______________________________

REASON FOR REFERRAL:

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PLEASE SEND A COPY OF PATIENTS REGISTRATION INFORMATION AND CHART NOTES WITH THIS FORM.

SIGNATURE: ____ DATE: _______________________

Ashland Office
648 N. Main Street
Ashland, OR 97520
P: (541) 482-8100

Yreka Office
2524 Westside Road
Yreka, CA 96097
P: (530) 842-2760