Cardinal Vision LLC
4723-A Sunset Blvd
Lexington, SC 29072
(803) 999-EYES Fax: (425) 448-6516
www.cardinalvision.com

please e-mail or fax this form to:
doctor.office@cardinalvision.com
(425) 448-6516

Cardinal Vision LLC
PROVIDER REFERRAL FORM

Referral Priority Request
☐ Emergent – **Please call**
☐ Urgent – Within 7 days
☐ Next Available Appointment

Location
☐ Lexington

Date of Referral: _____/_____/_____

Requested Physician:
Dr. Gavin Davis

REFERRING PROVIDER INFORMATION			
Doctor's Name:		NPI #	
Practice Name:			
Street:	City:	State:	Zip Code:
Provider's Email:	Phone # ( ) -	Direct Fax # ( ) -	

PATIENT INFORMATION			
Patient's Last Name:	First Name:	MI:	
Street:	City:	State:	Zip Code:
Date of Birth: _____/_____/_____	Race:	Gender: ☐ Male ☐ Female	
Phone #1: ( ) -	Phone #2: ( ) -	Phone #3: ( ) -	
Primary Insurance **(please attach front and back copy of insurance card)**			

If the patient's insurance requires authorization, please secure prior to submitting referral.

Authorization #:_____ Authorized # of Visits:_____

Authorized Dates From:____/_____/____ To:_____/_____/_____

Category of Referral:
☐ Diagnostic Evaluation ☐ Surgical Options
☐ Medical Management ☐ Transfer of Care
☐ Special Request:_____

Reason for Referral/Consult:_____
_____
_____

Diagnosis and ICD10 Code:_____

Thank you for your referral!
www.CardinalVision.com