



Provider Referral Form
Ask about same-day appointment availability.

Print all information legibly.

Patient Name (Last, First) _____ Date of Request (mm/dd/yy) _____

Referring Provider (Last, First) _____
(Street, Suite #) _____

(City, State, Zip Code) _____

(Office Phone #### - #### - #####) _____

Provide eye exam results if applicable:

Refraction: _____ Add: _____ Best Visual Acuity: _____
Right _____
Left _____

Intraocular Pressure:
Right _____ mm Hg Left _____ mm Hg Time: _____ a.m./p.m.

Consult Only **Consult & Treat** **Date of Onset:** _____

Evaluate or treat my patient for the following:

- | | |
|--------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Foreign Body |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Chalazion | <input type="checkbox"/> Low Vision |
| <input type="checkbox"/> Congenital Eye Disorder | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Conjunctivitis | <input type="checkbox"/> Macular Disease |
| <input type="checkbox"/> Corneal Abrasion/Ulcer | <input type="checkbox"/> Neuro-Ophthalmology |
| <input type="checkbox"/> Corneal Disease | <input type="checkbox"/> Ocular Immunology/Uveitis |
| <input type="checkbox"/> Cosmetic | <input type="checkbox"/> Pediatrics/Strabismus |
| <input type="checkbox"/> Dermatochalasis | <input type="checkbox"/> Pterygium |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Ptosis |
| <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Entropion/Ectropion | <input type="checkbox"/> Refractive Surgery/LASIK |
| <input type="checkbox"/> Enucleation | <input type="checkbox"/> Retinal Hemorrhage |
| <input type="checkbox"/> Epiphora | <input type="checkbox"/> Routine Eye Care |
| <input type="checkbox"/> Eye Pain/Redness | <input type="checkbox"/> Sjögren's Syndrome |
| <input type="checkbox"/> Eyelid Lesions | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Flashes/Floaters/Retinal Tear | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fluorescein Angiography | |

Appointment Urgency:

- Immediate 36 Hours 1 Week 3 Months
 24 Hours 72 Hours 1 Month 6 Months

Appointment Date/Time: _____

Wilmer Provider: _____

Call Center Access Line
410-955-5080
Toll Free: 1-888-Wilmer-i (945-6374)
Weekdays 8:30a.m. - 5:00p.m.

- The Johns Hopkins Hospital**
600 North Wolfe St.
Baltimore, MD 21287
P: 410-955-5080 F: 410-955-0468
- Johns Hopkins Bayview Medical Center**
4940 Eastern Ave.
Baltimore, MD 21224
P: 410-550-2360 F: 410-550-2231
- Bel Air**
620 Boulton St.
Bel Air, MD 21014
P: 410-893-0480 F: 410-893-9796
- Bethesda**
Westmoreland Building
6430 Rockledge Dr., Ste. 600
Bethesda, MD 20817
P: 240-482-1100 F: 240-482-1105
- Columbia**
Medical Pavilion at Howard County
10710 Charter Dr., Suite 310
Columbia, MD 21044
P: 410-910-2330 F: 410-910-2393
- Frederick**
161 Thomas Johnson Dr., Suite 275
Frederick, MD 21702
P: 301-620-9268 F: 301-620-9228
- Green Spring Station**
10753 Falls Rd., Pavilion II, Suite 455
Lutherville, MD 21093
P: 410-583-2802 F: 410-583-2842
- Odenton**
1106 Annapolis Rd., Suite 290
Odenton, MD 21113
P: 410-874-1425 F: 410-874-1429
- White Marsh**
4924 Campbell Blvd., Suite 100
White Marsh, MD 21236
P: 443-442-2020 F: 443-442-2021