New England
College of Optometry

CENTER FOR EYE CARE

Clinical Provider Referral

Date of Referral: ___________________

Patient Information

Patient: (First and Last Name) : ______________________________________ **DOB:** _____/_____/_____

Patient Address: ___________________________ **City:** __________________**State :** _____ **Zip**_________

Patient Phone Number: ___-___-____ **Patient Insurance:** ________________ **Member ID:** ____________

Referring Provider Information

Referring Provider (First and Last name): ____

Name of Practice/Facility: ____

Provider Address: ____________________________ **City:** __________________**State :** _____ **Zip**_______

Provider Phone Number ___-___-____ **Fax Number:** ___________________________________

Email Address: ____

Reason(s) for Referral Request

_____ **General eye examination and / or ocular disease care**
(annual examination, diabetic eye examination, floaters, flashes of light, conjunctivitis, red eye, etc.)
_____ **Specialty Contact Lens Services (keratoconus, orthokeratology, dry eye, etc.)**
_____ **Pediatric Care and/or Vision Therapy Services**
_____ **Low Vision Services**
_____**Other (describe patient condition):** ____

Attachments Included

____ **Patient demographic information** (Contact Information, Insurance Provider, etc.)
____ **Applicable Clinical Notes** (Recent eye exam, diagnostic codes, referring provider examination, diagnoses)

Appointment Preference (date, time): ____

NECO Center for Eye Care
Commonwealth
930 Commonwealth Ave
Boston, MA 02215
(P) 617-262-2020
(F) 617-236-6323

NECO Center for Eye Care
Roslindale
4199 Washington Street
Roslindale, MA 02131
(P) 617-323-7300
(F) 617-553-2121

New England Eye
Framingham
31 Flag Drive
Framingham, MA 01702
(P) 508-620-4956 x 2305
(F) 508-879-4909

Please fax your referral to one of our offices. If unsure of a location, please fax your referral to our Commonwealth Ave. office at (F) 617-236-6323.