CONSULTATION REQUEST FORM

Please call my patient and schedule a consultation based on the information provided below

Referring Doctor Name

Referring Doctor Phone Number

Referring Doctor Address

Referring Doctor Fax Number

Patient Name

Date Examined

Patient Phone Number

Patient Date of Birth

Primary Insurance

Policy Number

Secondary Insurance

Policy Number

☐ Urgent

☐ Next Available

Primary Treatment

The above patient is being referred for evaluation and consultation regarding

☐ AMD
☐ Diabetes
☐ ERM
☐ CME
☐ PVD
☐ Retinal Tear
☐ Retinal Detachment
☐ Other _____

Most recent refraction OD _____ OS _____

Date _____

BVA OD 20/ _____ OS 20/ _____

IOP OD _____ Time _____ ☐ AM ☐ PM

OS _____ ☐ NCT ☐ Goldman ☐ Other

Retinal Consultants of Arizona Location Preference

☐ Phoenix - North
☐ Phoenix - Biltmore
☐ Mesa
☐ Gilbert
☐ Peoria
☐ Other _____
☐ Closest to Patient

Please fax this form and notes to 602.231.6266 or email to referrals@retinalconsultantsaz.com

Retinal Consultants of Arizona

Our staff will contact your patient to schedule an appointment. To schedule an appointment immediately, please call **602.222.2221**.