Medical Consult Request

Name of Referring Provider/Facility: _____

Address:_____ City/State/Zip Coe:_____

Phone:_____ Fax:_____

Patient Name:_____ Date of Birth: _____Phone:_____

Referral is made to the following physician/specialist:

Dr. _____

Type of specialty consult requested:

_____

Patient Symptoms: _____

_____

Diagnosis: _____

Purpose of consultation:

____Cataract Surgery
____Glaucoma
____Dry Eye Disease
____Corneal Disease
____LASIK/PRK surgery
____Macular Degeneration
____Diabetic Eye Disease
____ Eyeglasses/contact lens prescriptions
____Other

Additional Notes:_____

_____