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

☐ Cataract
  ☐ Yes, Co-Manage
☐ Cloudy Capsule/Post-op Problem
☐ Glaucoma Suspect/Workup
☐ LASIK/ICL
  ☐ Yes, Co-Manage
☐ Cornea
☐ Eyelid/Oculoplastic
☐ Glaucoma Surgeon Consult
☐ Retina
☐ Other ______
☐ Cosmetic Consult

Most recent refraction OD ______ **BVA** OD 20/ ______

Date ______ OS ______ OS 20/ ______

IOP OD ______ Time ______ ☐ AM ☐ PM

OS ______ ☐ NCT ☐ Goldman ☐ Other

Choose the location Preference

☐ 2125 W Indian School Road Phoenix, AZ 85015

☐ 5620 W Thunderbird Rd., Suite C-5 Glendale, AZ 85306

☐ 160 W University Dr Mesa, AZ 85201

Please fax this form and notes to:

FAX 602.266.2861 (Phoenix) FAX 602.266.2861 (Glendale) FAX 480.835.7551 (Mesa)