***Practice*___________________________**
Doctor_____________________________
Address___________________________
City, State, Zip________________________
Phone: ______________Fax:___________

Request for Consultation

Date:____________________________

PATIENT INFORMATION

Patient Name: ____ D.O.B.: ________________________
If Minor- Guarantor's Name:____
Address: ____ City: ____________________ State: ______ Zip:__________
Phone #1: ______________________________________ Phone #2: ____
Insurance Plan: _____________________________ ID #: ____________________________________ Self-Pay □_______

Referring Physician: Please fax clear copy of both sides of patient's insurance card

CONSULT REQUEST

I would like to have your assistance with this patient's care. Please evaluate this patient's ocular and visual complaints, and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient and would be happy to resume the general care of the patient following your consultation and treatment and/or recommendations, as appropriate.

For Glaucoma Referrals please send a copy of the patient's past Visual Fields and Glaucoma Patient Data Sheet.
For Strabismus Referrals please include most recent refraction with prism if applicable.

☐ **History of LASIK/Refractive** ☐ **Contact Lens Wearer**

Please describe the condition(s) to be evaluated and past ocular history: ____
____
____
____

Most Recent Refraction:
If applicable

Sphere	Cylinder	Axis	Prism	Base	Add

Best Corrected Visual Acuity

OD 20/_______

OS 20/_______

Signature of Provider Requesting Consultation

Signature: ____ **Date**: ___________________

Preferred Location:___________________ **Preferred Ophthalmologist**: ____________________ **Urgency ___________**

APPOINTMENT SCHEDULING

□ Please call patient to schedule, note appointment below and fax back to my office. PSR Initials: __________
□ Please contact patient for billing information.
□ I have already scheduled an appointment on the patient's behalf, as noted below:

Date: _______________ Time: ___________ Location: _________________ Provider: __________________

Please fax this completed form to: (715) 261-8665 or (715) 261-8671