

CONSULTATION REQUEST

Today's Date: _____

Referring Physician: _____

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Gender: ☐ Male ☐ Female DOB: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Main Phone #: _____ Alternate phone #: _____

Contact name: _____ Email: _____

Medical Insurance: _____

Policy ID: _____ Group: _____

Policy Holder: _____ DOB: _____

PLEASE CALL US DIRECTLY FOR URGENT OR EMERGENT CONSULT REQUEST

Diagnosis / Reason for consult:

- | | |
|--|--|
| <input type="checkbox"/> Failed vision screen
<input type="checkbox"/> Eye crossing (strabismus)
<input type="checkbox"/> Tear duct disorders
<input type="checkbox"/> Eye movement disorders (nystagmus)
<input type="checkbox"/> Drooping or misshapen eyelids and hemangiomas
<input type="checkbox"/> Down Syndrome, cerebral palsy or cortical blindness | <input type="checkbox"/> Orbital infections and tumors
<input type="checkbox"/> Disorders of eye movement and double vision
<input type="checkbox"/> Retinopathy of prematurity, retinal malformation, retinoblastoma and optic nerve disorders
<input type="checkbox"/> Other
_____ |
|--|--|

Please attach clinical notes and patient demographics.

We will contact your patient and set up a convenient appointment.