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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:

- ☐ Failed vision screen
- ☐ Eye crossing (strabismus)
- ☐ Tear duct disorders
- ☐ Eye movement disorders (nystagmus)
- ☐ Drooping or misshapen eyelids and hemangiomas
- ☐ Down Syndrome, cerebral palsy or cortical blindness
- ☐ Orbital infections and tumors
- ☐ Disorders of eye movement and double vision
- ☐ Retinopathy of prematurity, retinal malformation, retinoblastoma and optic nerve disorders
- ☐ Other ___________________________

Please attach clinical notes and patient demographics.

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