

# Request For Eye Consultation

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Patient SS #: \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dear Dr. \_\_\_\_\_:

I am sending this patient to you for assistance with his/her care. Please evaluate this patient and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient, and will resume general care following your consultation.

- |                                   |                                       |                                |
|-----------------------------------|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Poor Vision  | <input type="checkbox"/> Other |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pain         | _____                          |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Foreign Body | _____                          |

Signed: \_\_\_\_\_  
*Referring Doctor*

*Please send this form via fax in advance of the patient's scheduled appointment, or ask the patient to bring this form on the day of the appointment.*

FAX Number: (864)458-3894

Telephone Number: (864)458-3900

Internal Use Only	
Account #:	_____
Appt. Date:	_____
Authorization Needed:	_____
Person Sending:	_____