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.

❑ Diabetes	❑ Poor Vision	❑ Other
❑ Glaucoma	❑ Pain	_____
❑ Cataract	❑ 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: _____