Pennsylvania Retina Specialists, PC

CONSULT REQUEST DOCUMENTATION FORM

Please assist us in caring for your patient by completing the form below. Please keep the original in your medical record for this patient and fax the completed form to us at (717) 761-5604 in advance of the patient's scheduled appointment. Thank you for referring your patient in need of retinal care to us.

Patient name _____ DOB _____

Appointment date _____

Dear Doctor:

I am sending this patient to you for assistance with his/her care. Please evaluate this patient's problem(s) or condition(s) described below and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient, and will resume care following your consultation.

Visual acuity OD _____ OS _____ IOP (if relevant) OD _____ OS _____

☐ Diabetic Retinopathy ☐ Macular Degeneration ☐ Vein Occlusion ☐ PVD

☐ Retinal Tear ☐ Retinal Detachment ☐ Macular Hole ☐ Pucker/ERM

Other _____

_____

Requesting Doctor _____ Date _____
(Print Name)