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www.soundretina.com

CONSULTATION REQUEST

Referring Doctor ______________________ Patient Name ______________________

Phone ______________________ Phone ______________________

Date of Exam ______________________ DOB ______________________

PATIENT INFORMATION

Reason for Consultation: ☐ OD ☐ OS ☐ OU

- ☐ Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Macular Hole and/or Pucker
- ☐ Possible Retinal Detachment
- ☐ Possible Retinal Tear or Posterior Vitreous Detachment
- ☐ Retinal Vascular Disease (BRVO, CRVO, BRAO/CRAO)
- ☐ Ocular Trauma or Tumor
- ☐ Uveitis
- ☐ Other______________________

Relevant Exam Findings: VA OD ____________ VA OS ____________

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Recommendation To Patient: ____

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☐ Appointment Information:

- ☐ I have scheduled this patient to be seen at Sound Retina on (date)__________ at (time) __________
- ☐ I would like Sound Retina to phone this patient to schedule an appointment

Signature: ____
(optional)