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Consultation Request

Patient Name:_____ Date:_____

Please Evaluate and Consider Treatment for:

__Diabetic retinopathy	__Epiretinal membrane	__Macular degeneration
__Macular hole	__Pigmented lesion	__Retinal tear(s)
__Retinal detachment	__Uveitis	__Visual loss
__Vitreous detachment	__Vitreous hemorrhage	__Visual distortion
__Other(s):		

I look forward to receiving your opinion and advice regarding care of this patient, and will resume general care following your consultation.

Special requests:

Requesting Doctor's Name_____

Please send this form via fax in advance of the patient's scheduled appointment