314-367-1181
800-888-0011
TRI-STL.com

THE RETINA INSTITUTE

Consultation Request

Telephone 314-367-1181 x-2292

FAX 314-968-3375

To:

- ☐ Kevin J. Blinder, MD
- ☐ Sabin Dang, MD
- ☐ Alia K. Durrani, MD
- ☐ Nicholas E. Engelbrecht, MD
- ☐ M. Gilbert Grand, MD
- ☐ Daniel P. Joseph, MD, PhD
- ☐ Thomas K. Krummenacher, MD
- ☐ Richard J. Rothman, MD
- ☐ Bradley T. Smith, MD
- ☐ Gaurav K. Shah, MD
- ☐ Special Testing

From ____________________ Telephone ____________________

Address ____________________ Fax: ____________________

Patient's Name ____________________ **Date of Birth** ____________________

I am requesting a consult to evaluate this patient's: ☐ OD ☐ OS ☐ OU

For:

- ☐ Macular Degeneration
- ☐ Retinal Tear / Retinal Detachment
- ☐ Vitreous Hemorrhage
- ☐ Macular Hole / Macular Pucker
- ☐ Other ____________________

Please consider treatment as appropriate. I look forward to receiving your opinion and advice regarding this patient, and will resume general care following your consultation.

Signed: (Referring Doctor's Signature) ____________________ Patient's Appointment Date ____________________

Please fax this form, along with the patient's chart notes or letter in advance of the patient's scheduled appointment, or send with patient for emergency consultation. We are happy to provide this service to you and your patient

Thank you,

THE PHYSICIANS AND STAFF OF THE RETINA INSTITUTE

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Images for Consultation

Your Information

Physician/Office: ______________________________

Specialty: ______________________ Telephone: ______________________

Patient's Information

Patient Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: ______________________ Date of Birth (DOB): ______________________

Insurance Information

Insurance #1: ______________________________

Policy #: ______________________ Group #: ______________________

Subscriber: ______________________ Subscriber's DOB: ______________________

Insurance #2: ______________________________

Policy #: ______________________ Group #: ______________________

Subscriber: ______________________ Subscriber's DOB: ______________________