Kevin J. Blinder, MD
Sabin Dang, MD
Alia K. Durrani, MD
Nicholas E. Engelbrecht, MD
M. Gilbert Grand, MD

THE RETINA INSTITUTE

Daniel P. Joseph, MD, PhD
Thomas K. Krummenacher, MD
Athanasios Papakostas, MD
Gaurav K. Shah, MD
Bradley T. Smith, MD

Administrative Office: 2201 S. BRENTWOOD BLVD. / ST. LOUIS, MISSOURI 63144 / 314.367.1181 or 800.888.0011 / fax: 314.968.5117 / TRI-STL.com

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
☐ Athanasios Papakostas, MD
☐ Gaurav K. Shah, MD
☐ Bradley T. Smith, 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

The information contained in this FAX message is confidential and may contain privileged patient medical records and/or information protected under federal and/or state law and is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient , you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the individual listed as the **SENDER** of this message.

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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: ____________________