RETINA ASSOCIATES of Southern Utah

Leader in Advanced Retinal Treatment and Surgery

Patient Name: ________________________________ DOB: _______________

Exam Date:______________ Patient Phone: _____________________________

Referring Doctor:________________________________

Dr. Lord/Carlson,

I am sending this patient to you for assistance with his/her care. Please evaluate this patient's problem(s) or condition(s):

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____

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

Signed: ____
(Referring Doctor)

Please have the patient scheduled:

- ☐ Same Day (phone contact requested)
- ☐ Next Day (phone contact requested)
- ☐ Within 1 week
- ☐ Within 2 weeks

How would you like to be notified of the results of the consultation?

- ☐ Mail report to:____
- ☐ Fax the report to:____
- ☐ Call the referring Doctor with results at: ____________________________________

Thank you for the opportunity to assist in the care of your patient. Please fax this form to **866-836-9639** in advance of your patient's appointment **along with your most recent patient chart/medical records and notes**, and ask the patient to bring a copy of this form on the day of appointment.

Instructions to Patient:
Please bring this form with you to our office.
Your eyes will be dilated and we advise that you have a driver.
You will be in our office approximately two hours. If you need a referral from your insurance plan, please be sure to obtain one prior to your visit.
Please bring your insurance cards, a photo ID and a list of any medication that you are currently taking.