



351 NW LEJUNE ROAD, SUITE # 302
MIAMI, FL 33126

Consultation Request Form

Date: _____

Patient Name: _____ D.O.B: _____

Address: _____ City _____ State _____ Zip Code _____

Phone #: _____ Cell #: _____

Patient Insurance: _____

Referring Dr.: _____ Phone #: _____

Practice Address: _____ Fax #: _____

Retina Specialist of South Florida

Dear Dr. Lara:

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

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.

Routine

Emergency

Please send this information via fax to (305) 643-8872 in advance of the patient's scheduled appointment, or ask the patient to bring this form on the day of the appointment.

Signed _____

(Referring Doctor)

Retina Specialist of South Florida thanks you for your referral.