



THE RETINA INSTITUTE

Administrative Office: 1600 S. BRENTWOOD BLVD. / SUITE 800 / 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Kevin J. Blinder, MD | <input type="checkbox"/> M. Gilbert Grand, MD | <input type="checkbox"/> Gaurav K. Shah, MD |
| <input type="checkbox"/> Sabin Dang, MD | <input type="checkbox"/> Daniel P. Joseph, MD, PhD | <input type="checkbox"/> Bradley T. Smith, MD |
| <input type="checkbox"/> Alia K. Durrani, MD | <input type="checkbox"/> Thomas K. Krummenacher, MD | <input type="checkbox"/> Special Testing |
| <input type="checkbox"/> Nicholas E. Engelbrecht, MD | <input type="checkbox"/> Richard J. Rothman, MD | |

From _____

Telephone _____

Address _____

Fax: _____

Patient's Name _____

Date of Birth _____

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

For:

- | | |
|--|--|
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Macular Hole / Macular Pucker |
| <input type="checkbox"/> Retinal Tear / Retinal Detachment | |
| <input type="checkbox"/> Vitreous Hemorrhage | <input type="checkbox"/> 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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