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
Richard J. Rothman, MD
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Bradley T. Smith, MD

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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
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- ☐ Richard J. Rothman, 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