



# CONSULTATION REQUEST

Date \_\_\_\_\_

### Type of Consult:

- Cataract
- Cornea
- Glaucoma
- LASIK/Refractive Surgery
- Lids/Oculoplastic
- Pediatric/Adult Eye Muscle
- Retina
- Specialty Contact Lens
- Other \_\_\_\_\_

Patient Name \_\_\_\_\_  
(First) (Middle) (Last)

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_  
(Parent name if minor)

Patient Gender  Male  Female

Patient Birth Date \_\_\_\_\_ Patient Phone \_\_\_\_\_

Patient Address \_\_\_\_\_

Insurance Name \_\_\_\_\_ Subscriber Date Of Birth \_\_\_\_\_

Subscriber \_\_\_\_\_

Appointment Date/Time Or Requested By Date \_\_\_\_\_

Interpreter  Yes  No Language \_\_\_\_\_

I am referring the patient for

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I Wish To Co-Manage with \_\_\_\_\_

Consulting/Referring Provider \_\_\_\_\_ Phone \_\_\_\_\_  
(Please Print)

Clinic Name \_\_\_\_\_

Provider Address \_\_\_\_\_ Fax \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)

Please contact \_\_\_\_\_ at clinic if further information is needed

Email Address \_\_\_\_\_

Signature \_\_\_\_\_

STILLWATER  
HUGO  
WOODBURY  
NEW RICHMOND  
HUDSON

AFFILIATED CLINICS IN:  
AMERY  
BALDWIN

- |                                |                                |                                  |                               |
|--------------------------------|--------------------------------|----------------------------------|-------------------------------|
| Alan A. Downie, M.D.           | David H. Park, M.D.            | Jesse M. Vislisel, M.D.          | Ryan M. Fedor, O.D.           |
| Adam D. Goddard, D.O.          | Susan Schloff, M.D.            | Charlie W. Wu, M.D.              | Ann M. Hickson, O.D.          |
| Jeffrey T. Lynch, M.D., M.P.H. | Gary S. Schwartz, M.D., M.H.A. | Laura L. Capelle, O.D., F.A.A.O. | Jacob R. Lang, O.D., F.A.A.O. |
|                                | Brian J. Tienor, M.D.          |                                  | Sean M. LaVallie, O.D.        |