## **CONSULTATION REQUEST FORM**

Please call my patient and schedule a consultation based on the information provided below

Referring Doctor Name	Referring Doctor Phone Number
Referring Doctor Address	Referring Doctor Fax Number
Patient Name	Date Examined
Patient Phone Number	Patient Date of Birth
Primary Insurance	Policy Number
Secondary Insurance	Policy Number
<ul> <li>□ Urgent</li> <li>□ Next Available</li> <li>Primary Treatment</li> </ul>	
The above patient is being referred for evaluation and consu	ultation regarding
☐ Cataract ☐ Cloudy Capsule/Post-op Problem ☐ Yes, Co-Manage	☐ Glaucoma Suspect/Workup ☐ LASIK/ICL ☐ Yes, Co-Manage
☐ Cornea ☐ Eyelid/Oculoplastic	☐ Glaucoma Surgeon Consult ☐ Retina
☐ Other ☐ Cosmetic Consult	J
Most recent refraction OD	<b>BVA</b> OD 20/
Date OS	OS 20/
IOP OD	Time
OS	□ NCT □ Goldman □ Other
Southwestern Eye Center Location Preference  Mesa-Stapley Apache Junction  Mesa-Falcon Field Scottsdale-Bell Rd.  Mesa- Main Scottsdale-Miller Rd.  Mesa- Gilbert Maryvale	<ul> <li>☐ Tempe</li> <li>☐ Sun City</li> <li>☐ Sun City West</li> <li>☐ Anthem</li> </ul>

Please fax this form and notes to 602.231.6240 or email to referrals@americanvisionpartners.com



Our staff will contact your patient to schedule an appointment. To schedule an appointment immediately, please call 602.598.7640.

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