

# 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

Urgent

Next Available Primary Treatment

## The above patient is being referred for evaluation and consultation regarding

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Cataract<br><input type="checkbox"/> Yes, Co-Manage | <input type="checkbox"/> Cloudy Capsule/Post-op Problem | <input type="checkbox"/> Glaucoma Suspect/Workup  | <input type="checkbox"/> LASIK/ICL<br><input type="checkbox"/> Yes, Co-Manage |
| <input type="checkbox"/> Cornea  | <input type="checkbox"/> Eyelid/Oculoplastic            | <input type="checkbox"/> Glaucoma Surgeon Consult | <input type="checkbox"/> Retina   |
| <input type="checkbox"/> Other _____   | <input type="checkbox"/> Cosmetic Consult               |   |   |

Most recent refraction

OD \_\_\_\_\_

BVA

OD 20/ \_\_\_\_\_

Date \_\_\_\_\_

OS \_\_\_\_\_

OS 20/ \_\_\_\_\_

IOP OD \_\_\_\_\_

Time \_\_\_\_\_  AM  PM

OS \_\_\_\_\_

NCT  Goldman  Other

## Southwestern Eye Center Location Preference

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Mesa-Stapley      | <input type="checkbox"/> Apache Junction       | <input type="checkbox"/> Tempe         | <input type="checkbox"/> Closest to Patient |
| <input type="checkbox"/> Mesa-Falcon Field | <input type="checkbox"/> Scottsdale-Bell Rd.   | <input type="checkbox"/> Sun City      |   |
| <input type="checkbox"/> Mesa- Main        | <input type="checkbox"/> Scottsdale-Miller Rd. | <input type="checkbox"/> Sun City West |   |
| <input type="checkbox"/> Mesa- Gilbert     | <input type="checkbox"/> Maryvale              | <input type="checkbox"/> Anthem        |   |

Please fax this form and notes to 602.231.6240 or email to [referrals@americanvisionpartners.com](mailto:referrals@americanvisionpartners.com)



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