

RETINA ASSOCIATES OF KENTUCKY

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CONSULTATION REQUEST FORM

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Phone: _____ Cell Phone: _____

SS#: _____

Reason for Consultation: _____

Name of Referring Physician: _____ **Phone #:** _____
(Please Print)

Signature of Referring Physician: _____ **City, State** _____

Retina Associates of Kentucky Office Locations (please circle desired location)

ASHLAND BARDSTOWN DANVILLE FRANKFORT LEXINGTON LONDON
LOUISVILLE PRESTONSBURG RICHMOND SHELBYVILLE SOMERSET

Primary Insurance: _____ Secondary Insurance: _____

Subscriber: _____ DOB _____ Subscriber: _____ DOB _____

Subscriber ID#: _____ Subscriber ID#: _____

Group #: _____ Group #: _____

Please send front and back copies of current insurance cards

Nursing Home Patient: YES NO

Nursing Name: _____

Nursing Home Address: _____

Nursing Home Phone #: _____

Worker's Comp: YES NO

Worker's Comp Carrier: _____

Claim #: _____

Date of Injury: _____

W/C Carrier Phone #: _____

For Office Use Only:

Consult Received by Phone: YES NO Spoke to: _____ Date/Time: _____

Consult Form: **FAXED / MAILED** Date Received: _____

Appointment Date and Time: _____

Faxed Consult Form to Referring Physician YES NO Date faxed: _____

New Patient Information Sent: YES NO