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