



Consultation Request

Today's Date: _____

Lexington telephone: (859) 263-3900
Louisville telephone: (502) 895-2600

PATIENT DEMOGRAPHIC INFORMATION

Name: _____

DOB: _____ Social Security #: _____

Address: _____

_____ Zip: _____

Phone: _____ Cell: _____

Primary / Secondary Insurance Self-pay

PROVIDER INFORMATION

Provider Name: _____

Provider Phone: _____

Provider Fax: _____

Provider Signature: _____

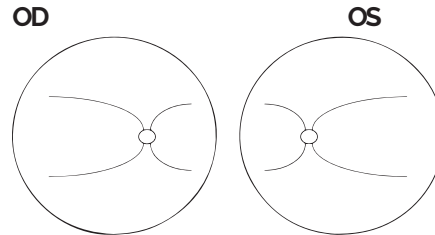
PLEASE SEND FRONT AND BACK COPIES OF CURRENT INSURANCE CARDS

BRIEFLY STATE THE REASON FOR THE REFERRAL

Vision OD 20 / ____

 OS 20 / ____

Fundus findings



URGENT CONSULTATION FOR:	ROUTINE CONSULTATION FOR:	REQUESTED APPOINTMENT LOCATION
<input type="checkbox"/> Wet AMD RT LT <input type="checkbox"/> Retinal Detachment RT LT <input type="checkbox"/> Retinal Tear RT LT <input type="checkbox"/> Vitreous Hemorrhage RT LT <input type="checkbox"/> Endophthalmitis RT LT <input type="checkbox"/> Other: _____	<input type="checkbox"/> Dry AMD RT LT <input type="checkbox"/> BRVO / CRVO RT LT <input type="checkbox"/> Epiretinal Membrane RT LT <input type="checkbox"/> Diabetic Macular Edema RT LT <input type="checkbox"/> Diabetic Retinopathy RT LT <input type="checkbox"/> Macular Hole RT LT <input type="checkbox"/> Other: _____	<input type="checkbox"/> Lexington <input type="checkbox"/> Louisville <input type="checkbox"/> Ashland <input type="checkbox"/> Bardstown <input type="checkbox"/> Danville <input type="checkbox"/> Frankfort <input type="checkbox"/> London <input type="checkbox"/> Prestonsburg <input type="checkbox"/> Richmond <input type="checkbox"/> Shelbyville <input type="checkbox"/> Somerset
<p>IF YOU ARE SCHEDULING AN URGENT CONSULTATION, PLEASE CALL OUR OFFICE DIRECTLY (800) 627-2020</p>		<p>For office use only: Appt Date and Time: _____</p>

Nursing Home Patient: YES NO

Nursing Home Name: _____

Nursing Home Phone: _____

Nursing Home Address: _____

Worker's Comp: YES NO

Worker's Comp Carrier: _____

Claim #: _____

Date of Injury: _____

W/C Carrier Phone #: _____

Retina Associates of Kentucky - All Locations
Fax to: (859) 264-2911
Toll Free: (800) 627-2020

Upon receipt, we will contact your patient within one business day to schedule the requested appointment. We will also contact your office to inform you of the upcoming appointment date/time. Please provide your contact information if you would like us to notify you specifically.

PLEASE FAX CHART NOTE