

Request for Services

Patient Information (Please attach patient demographics and health insurance information)

Name: _____ DOB: ____ / ____ / ____ Phone: (____) _____

Appointment and Referring Provider Information

Appt Date / Time: _____ / _____

Please schedule directly with the patient

Full Consult
(Exam, interp, & recommendation)

Testing Only
(Tech only, no interpretation)

Referring Provider (please print): _____ Phone: (____) _____

Preferred Method of Contact: Phone / Letter / Email _____

Area(s) of Interest

Cornea Macula Retina Lens Optic Nerve
Lids Skin Conj Other: _____

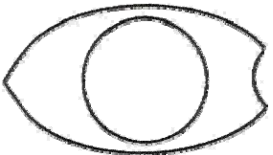
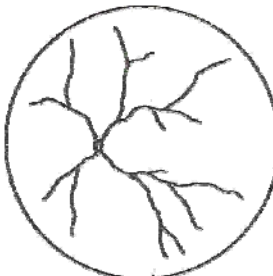
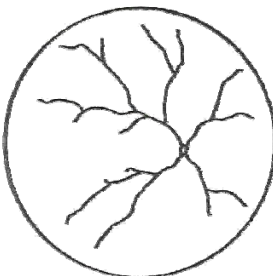
Suspected or Known Diagnosis

ARMD Cataract Glaucoma Diabetes PCO
Other: _____

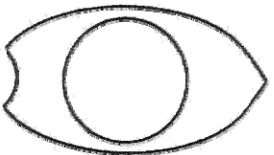
Desired Testing

HRT3 OCT VF Fundus Photo FA External Photo

Drawings and Notes



RT



LT