

Today's Date: _____

REQUEST FOR CONSULTATION

Referring Doctor: _____ Doctor's Phone #: _____

Patient Name: _____ Date of Birth: _____

Dear St. Luke's doctor:

I am requesting assistance with the care of my patient. Please evaluate his/her problem(s) or condition(s) and consider treatment as appropriate.

I look forward to hearing from you regarding your assessment and suggested care. Upon completion of your consultation and/or treatment, I will resume his/her general care.

Consulting Doctor: _____

Reason for consultation:

- | | |
|--|--|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Posterior Capsule Opacification |
| <input type="checkbox"/> Decreased Vision | <input type="checkbox"/> Cornea |
| <input type="checkbox"/> Diabetic Eye Care | <input type="checkbox"/> Glaucoma/Ocular Hypertension |
| <input type="checkbox"/> Oculoplastics | <input type="checkbox"/> Retinal/Macular Degeneration |
| <input type="checkbox"/> Other _____ | |



Please Fax or Send with Patient

Fax: 727.938.5606

Phone: 727.938.2020