LAZAR
RETINA

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CONSULTATION REQUEST FORM

Patient Name _____ Phone _____ D.O.B _____

Referring Doctor _____ Office Location _____

Phone _____ Fax _____ Email _____

Reason:

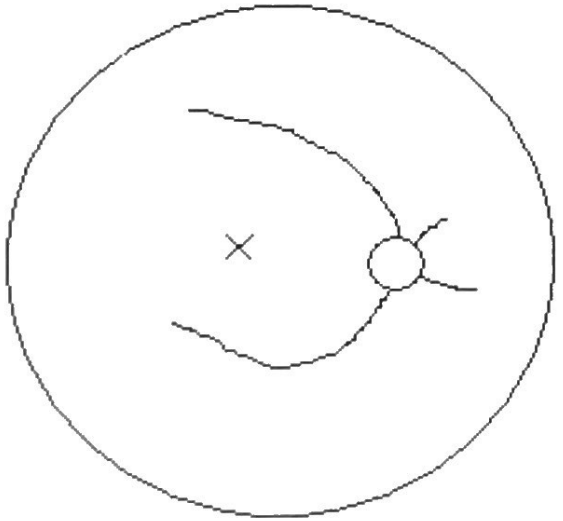
- ❑ Macular Degeneration
- ❑ Diabetic Retinopathy
- ❑ Tear/Detachment
- ❑ Unexplained Vision Loss
- ❑ Other: _____

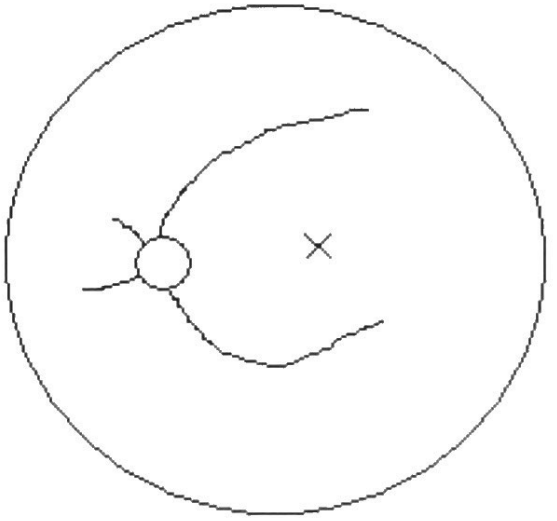
Referral Instructions:

- ❑ Consult and Treatment
- ❑ Fluorescein Angiogram
- ❑ OCT
- ❑ Ultrasound (B-Scan)
- ❑ Testing Only: _____

Preferred Contact:

- ❑ Email
- ❑ Fax
- ❑ Call





Instructions to Patient:

❑As your eyes will be dilated, it is recommended that you bring sunglasses and have an alternate driver.

❑Please be advised your initial appointment will last approximately 1 hour, plus 30 minutes for new patient paperwork.

❑Please bring your ID, insurance card/s, and a payment method to cover any co-pay amount.