CONSULTATION REQUEST FORM

Please call my patient and schedule a consultation based on the information provided below

Referring Doctor Name

Referring Doctor Phone Number

Referring Doctor Address

Referring Doctor Fax Number

Patient Name

Date Examined

Patient Phone Number

Patient Date of Birth

Primary Insurance

Policy Number

Secondary Insurance

Policy Number

☐ Urgent

☐ Next Available

Primary Treatment

The above patient is being referred for evaluation and consultation regarding

☐ Cataract ☐ Yes, Co-Manage

☐ Cloudy Capsule/Post-op Problem

☐ Glaucoma Suspect/Workup

☐ LASIK/ICL ☐ Yes, Co-Manage

☐ Cornea

☐ Eyelid/Oculoplastic

☐ Glaucoma Surgeon Consult

☐ Retina

☐ Other _____

☐ Cosmetic Consult

Most recent refraction OD _____

Date _____ OS _____

BVA OD 20/ _____

OS 20/ _____

IOP OD _____ Time _____ ☐ AM ☐ PM

OS _____ ☐ NCT ☐ Goldman ☐ Other

West Texas Eye Associates Location Preference

☐ Quaker Avenue

☐ 50th Street

☐ Laser Eye Center of Lubbock

☐ Cataract & Surgical Center of Lubbock

☐ Aesthetic Center of Lubbock

☐ Aesthetic Center of Midland

☐ Closest to patient

Please fax this form and notes to 806-792-6092

West Texas Eye Associates

Our staff will contact your patient to schedule an appointment. To schedule an appointment immediately, please call 806-792-6092.