CONSULTATION REQUEST
VitreoRetinal Surgery

Date: _____

To: VitreoRetinal Surgery
To ensure timely scheduling, please make every effort to schedule referral appointments while patient is still in your clinic – Thank you!

From: Clinic: _____
Doctor: _____
Address: _____
_____
Phone: _____

Patient Name: _____
Date of Birth: _____
Phone #: _____ **Cell #:** _____

I am sending this patient to you for assistance with his/her care. Please evaluate this patient's problem(s) or condition(s) (*describe)*:

and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient and will resume general care following your consultation.

Signed:_____
Referring Doctor Signature

Please send this form along with the patient's chart notes and/or a letter in advance of the patient's scheduled appointment.

Fax Numbers:

Edina	(952) 929-8873	St. Cloud	(320) 654-8663
St Paul	(651) 644-8994	Duluth	(218) 625-8179
Plymouth	(763) 550-1003	Oakdale	(651) 361-8101
Blaine	(763) 755-0277		

Thank you.