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	Woodbury	(651) 361-8101
Blaine	(763) 755-0277		

Thank you.