Connecticut Retina Consultants, L.L.C.

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Consultation Request Form to:

Connecticut Retina Consultants LLC

Referring Physician: _____

Patient Name: _____

DOB: _____ Phone: _____

Address: _____

Insurance name and ID#: _____

Appointment date given: _____

A request for the opinion/advice regarding evaluation and/or management for the above named patient has been made from the above named physician. The patient has been sent to CONNECTICUT RETINA CONSULTANTS, LLC for the evaluation of the following condition and/or reasons:

_____

_____

_____

The referring physician requesting this opinion understands that the consulting physician may initiate treatment or perform medically necessary diagnostics for this patient and that the consultant will provide a written report of his findings.

Referring office stamp/signature: _____ Date: _____

Please select the preferred location:

_____ New Haven office
(203) 787-6161-phone
(203) 776-0300-fax

_____ Madison office
(203) 245-4544-phone
(203) 779-5337-fax

_____ Hamden office
(203) 248-8080-phone
(203) 535-0860-fax

_____ Trumbull office
(203) 365-6565-phone
(203) 365-6567-fax

_____ Fairfield office
(203) 870-6113-phone
(203) 870-6115-fax

****Please fax form and office notes to selected office and file a copy in the patient's chart.**