RETINA CONSULTANTS OF MINNESOTA

CONSULTATION REQUEST

Date: _____

To: **Retina Consultants of Minnesota**
To ensure timely scheduling, please make every effort to schedule referral appointments while the 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
Blaine	(763) 755-0277	Duluth	(218) 625-8179
St. Louis Park	(763) 550-1003	Woodbury	(651) 361-8101
Maplewood	(952-460-5274)	Baxter	(952-460-5274)
Anoka	(952-460-5274)	Chaska	(952-460-5274)
Mankato	(952-460-5274)	Hutchinson	(952-460-5274)
Apple Valley	(952-460-5274)		