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)	Mankato	(507-385-1698)
Anoka	(763-421-2324)		