

## 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	(651) 773-5985	Baxter	(952) 460-5274
Anoka	(763) 421-2324	Glencoe	(952) 460-5274
Mankato	(507) 385-1698		