CONSULTATION REQUEST FORM

Please call my patient and schedule a consultation based on the information provided below

Referring Doctor Name

Referring Doctor Phone Number

Referring Doctor Address

Referring Doctor Fax Number

Patient Name

Date Examined

Patient Phone Number

Patient Date of Birth

Primary Insurance

Policy Number

Secondary Insurance

Policy Number

☐ Urgent

☐ Next Available

Primary Treatment

The above patient is being referred for evaluation and consultation regarding

☐ Cataract ☐ Yes, Co-Manage

☐ Cloudy Capsule/Post-op Problem

☐ Glaucoma Suspect/Workup

☐ LASIK/ICL ☐ Yes, Co-Manage

☐ Cornea

☐ Eyelid/Oculoplastic

☐ Glaucoma Surgeon Consult

☐ Retina

☐ Other _____

☐ Cosmetic Consult

Most recent refraction OD _____

Date _____ OS _____

BVA OD 20/ _____

OS 20/ _____

IOP OD _____ Time _____ ☐ AM ☐ PM

OS _____ ☐ NCT ☐ Goldman ☐ Other

Abrams Eye Institute Location Preference

☐ **Las Vegas**
6450 Medical Center, St #100
Las Vegas, NV 89148

☐ **Henderson**
2451 W Horizon Ridge Pkwy, Suite 130
Henderson, NV 89052

☐ **Pahrump**
1470 E Calvada Blvd, Suite 300
Pahrump, NV 89048

Abrams Eye Institute

Please fax this form and notes to:

Provider Referrals	OD PROVIDERS	PCP & OTHER PROVIDERS
Phone: 702-304-9494	Phone: 602-598-7588	Phone: 602-955-1000
Fax: 702-304-9495	Fax: 602-231-6240	Fax: 602-231-6250