# 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 ______ **BVA** OD 20/ ______

Date ______ OS ______ OS 20/ ______

**IOP** OD ______ Time ______ ☐ AM ☐ PM

OS ______ ☐ NCT ☐ Goldman ☐ Other

## Southwest Eye Institute Location Preference

☐ **East**
1400 Common Dr.
El Paso, TX 79936

☐ **West**
150 S. Resler Dr.
El Paso, TX 79912

☐ **Mesa**
4171 N. Mesa St. Bldg. D., Ste. 100
El Paso, TX 79902

☐ **Northeast**
9235 Dyer St.
El Paso, TX 79924

☐ **Las Cruces**
2301 Saturn Cir.
Las Cruces, NM 88012

**Please fax this form and notes to**

Call or Text 915.267.2020

Fax 915.595.4460

Southwest Eye Institute