

# 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  Cloudy Capsule/Post-op Problem  Glaucoma Suspect/Workup  LASIK/ICL  
 Yes, Co-Manage  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