RETINA VISION CONSULTANTS

Please fax this form to (310) 269-8011

Patient Information

Name	Date of Birth
Phone	

Reason for Referral

____ Retinal Detachment

____ Diabetic Retinopathy

____ Macular Degeneration

____ Retinal Vein/Artery Occlusion

____ Other:

____ Epiretinal Membrane

____ Full Thickness Macular Hole

____ Floaters

____ Dislocated Lens

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____ Consultation Only

____ Consultation and Treatment

Name of Referring Provider ____

____ Prefer communication via phone call

____ Prefer communication via letter

Preferred Provider (First available if none marked)

____ Dr. Kirk Hou ____ Dr. Pradeep Prasad ____ Dr. Steven Schwartz

Requested Appointment Time Frame

____ 1-2 Days ____ Within one week ____ Within one month

If you would like to speak with one of our physicians, please call our office at (310) 269-8565. Thank you for your referral.

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