THOMAS A. CIULLA, MD, PC
MIDWEST EYE INSTITUTE

REQUEST FOR CONSULTATION

Patient: _____ **Date of Birth**_____

Requestor of Consultation: _____

Requestor's Phone number: _____**FAX #**_____

Dear Dr. Ciulla,

I am requesting a Retinal Consultation for the above-named patient. Please evaluate this patient's problem (s) or condition (s) and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient, and will resume general eye care following your consultation.

Reason for consultation: RIGHT EYE LEFT EYE (circle one or both)

_____ Diabetic Retinopathy	_____ Macular Degeneration
_____ Macular Edema	_____ Macular Hole
_____ Retinal Artery Occlusion	_____ Retinal Vein Occlusion
_____ Retinal Tear	_____ Retinal Hole
_____ Retinal Detachment	_____ Endophthalmitis
_____ Uveitis	_____ Trauma
_____ PVD	_____ Epiretinal Membrane

Additional comments: _____

Signed _____Date of Request:_____
(Referring/ Requesting Doctor)

Patient has an appointment on ____/____/_____**at** _____ **o'clock.**
Please send this form via fax in advance of the patient's scheduled appointment to fax number (317) 817-1898.