Please complete this form and fax to us (see below for office fax numbers). We will be happy to contact your patient directly to schedule an appointment with Dr. Patel.

Location Requested: □ Frederick, Maryland □ Gettysburg, Pennsylvania

Patient: _____
First Middle Last

Date of Birth: ____/_____/_____ Sex: □ Male □ Female

Consult Requested by:

_____

Phone _____ Fax_____

Address_____

City_____State_____Zip_____

Dear Greater Potomac Retina Doctor:

I am sending this patient to you for assistance with his/her care. Please evaluate this patient's problem(s) or conditions(s) described below and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient and will resume general care following your consultation.

Visual Acuity: OD _____ OS _____

□ Macular Degeneration	□ Diabetic Retinopathy	□ PVD
□ Retinal Tear	□ Retinal Detachment	□ Macular Pucker
□ Macular Hole	□ Vein Occlusion	□ Other

Diagnostic findings or Pertinent History:

_____

Visit Requested:

□ Emergent *(immediately)* □ Urgent *(within 24 hrs.)*

□ Priority *(3-4 days)* □ Non-Urgent *(1-4 weeks)*

Signed: _____ Date: _____
Referred by

Print Referring Physician's Name: _____

Insurance Information (Optional)

Primary Insurance Company

_____

Subscriber Name_____

Birth date_____

Identification # (Please include all letters and spaces) _____