Patient Referral

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www.retinagroupofnewengland.com

Vitreo-Retinal Consult Order

Referring Physician: _____ Patient's Phone #: _____

Patient's Name: _____ Date of Birth: _____

Primary Eye to be Studied: ❑ **OD** ❑ **OS** ❑ **OU**

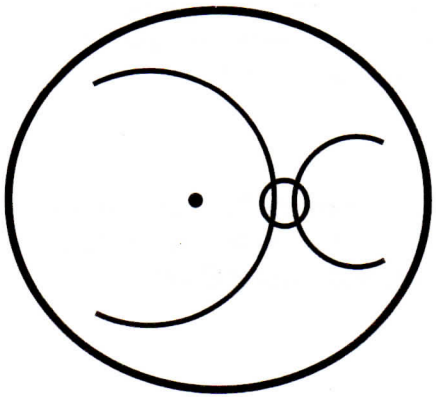
Doctor's Comments / Other Instructions / Present History

_____

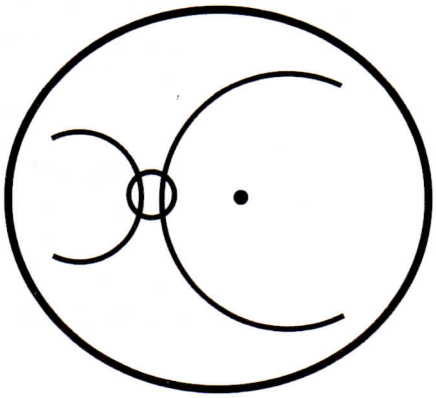
_____

_____

OD



OS



INSTRUCTIONS TO PATIENT:

Please bring this form with you to our office.
Your eyes will be dilated and we advise that you have a driver.
You will be in our office approximately two hours. If you need a referral from your insurance plan, please be sure to obtain one prior to your visit.

Appointment Date: _____ Time: _____

LOCATIONS

New London
400 Bayonet Street, Suite 206
New London, CT 06320
Phone: 860-444-1292
Fax: 860-444-1827

Norwich
79 Wawecus Street, Suite 109
Norwich, CT 06360
Phone: 860-887-6429
Fax: 860-887-7303

Branford
6 Business Park Drive, Suite 303
Branford, CT 06405
Phone: 203-458-0245
Fax: 860-444-1827

DIRECTIONS ON THE REVERSE SIDE.

White - Patient's Copy Yellow - Ordering Physician's Copy