

Consultation Request Form

**Sample Ophthalmology, PC
3345 Market Drive, Suite 200
Rochester, NY 10239**

**To: *John Doe, M.D.—Family Medicine, PC
12121 E. Centennial Rd., Suite 120
Rochester, NY 10239***

In an effort to adhere to strict compliance guidelines, we need to have the following Consultation Request form filled out and faxed back to our office at 808-999-0000 as soon as possible.

Patient Name: *Mabel Cartright* DOB: *01/02/38*

Date: *8/15/2004*

Insurance Co. *ABC Senior Plan* Referral # if applicable: *N/A*

Requesting Consultation for Opinion and or Advice regarding: *Hypertension and general physical stability to undergo cataract surgery 9/1/2004*

Please mail or fax written report to: ***Frank Jones, M.D.
Sample Ophthalmology
3345 Market Drive, Suite 200
Rochester, NY 10239***
(Requesting Provider Address)

Transfer of Care—please see and treat patient.
Written opinion or advice is not necessary.

Other: _____

We appreciate your confidence in our services and the opportunity to participate in your patient's care. If you have any questions, please feel free to contact Alice Smith, R.N. at our office. (808) 999-0001.

Sincerely,

Sample Ophthalmology, PC