

CONSULTATION REQUEST FORM

Please call my patient and schedule a consultation based on the information provided below

Referring Doctor Name

Referring Doctor Phone Number

Referring Doctor Address

Referring Doctor Fax Number

Patient Name

Date Examined

Patient Phone Number

Patient Date of Birth

Primary Insurance

Policy Number

Secondary Insurance

Policy Number

☐ Urgent

☐ Next Available Primary Treatment

The above patient is being referred for evaluation and consultation regarding

- | | | | |
|---|---|---|---|
| ☐ Cataract | ☐ Cloudy Capsule/Post-op Problem | ☐ Glaucoma Suspect/Workup | ☐ LASIK/ICL |
| ☐ Yes, Co-Manage | | | ☐ Yes, Co-Manage |
| ☐ Cornea | ☐ Eyelid/Oculoplastic | ☐ Glaucoma Surgeon Consult | ☐ Retina |
| ☐ Other _____ | ☐ Cosmetic Consult | | |

Most recent refraction

OD _____

BVA

OD 20/ _____

Date _____

OS _____

OS 20/ _____

IOP OD _____

Time _____ ☐ AM ☐ PM

OS _____

☐ NCT ☐ Goldman ☐ Other

M&M Eye Institute Location Preference

☐ **Prescott (Sardetto location)**

3192 Willow Creek Road
Prescott, AZ 86301

☐ **Prescott Valley**

3223 N. Windsong Dr.
Prescott Valley, AZ 86314

☐ **Chino Valley**

399 West Palomino Rd.
Chino Valley, AZ 86323

Please fax this form and notes to:



PRESCOTT CLINIC
(Sandretto)

Phone: (928) 323-0378

Fax: (928) 771-8107

PRESCOTT VALLEY

Phone: (928) 775-6121

Fax: (928) 775-6301

CHINO VALLEY

Phone: (928) 636-5504

Fax: (928) 636-0780