



DATE _____ DOB _____

PATIENT NAME _____

PHONE (HOME) _____ CELL _____

INSURANCE COMPANY _____

INSURED PERSON _____

AUTHORIZATION NO. _____

AUTHORIZED BY _____

REFERRING DOCTOR _____

ADDRESS _____

TELEPHONE _____

Referral for Retinal Consultation

EXAM RESULTS

PHONE LETTER FAX

DIAGNOSIS

- Macular Degeneration Diabetic Retinopathy Flashes/Floaters
- Retinal Detachment Retinal Tear Unexplained Vision Loss
- Other _____

AUTHORIZATION

I, _____ authorize release of all records pertaining to my care from my referring physician to Retina Consultants of Nevada.

YOUR APPOINTMENT

is on _____ with

- Dr. Parker
- Dr. Hollifield
- Dr. Loo
- Dr. Yepremyan
- Dr. Wickens
- Dr. Pezda
- Dr. Liu
- Dr. Calvo

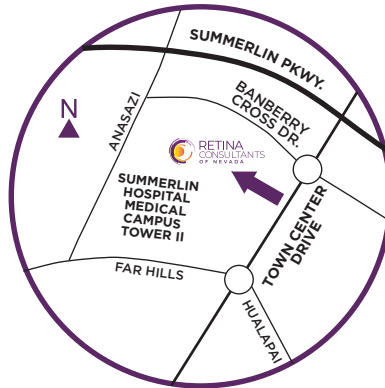
PLEASE BRING FORM WITH YOU TO YOUR APPOINTMENT

(702) 369-0200
(800) 228-5810

OUR LOCATIONS

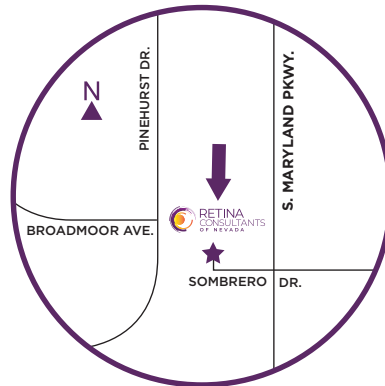
SUMMERLIN OFFICE

(702) 369-4143 FAX
653 N. TOWN CENTER DR.
SUITE 518
LAS VEGAS, NV 89144



EAST SIDE OFFICE

(702) 951-6010 FAX
3201 S MARYLAND PARKWAY,
SUITE 500
LAS VEGAS, NV 89109



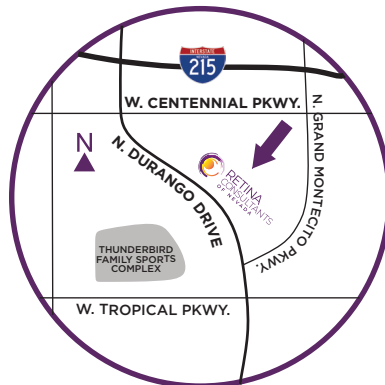
GREEN VALLEY OFFICE

(702) 851-9447 FAX
710 CORONADO CENTER DR.
SUITE 201
HENDERSON, NV 89052



CENTENNIAL OFFICE

(702) 405-6110 FAX
6220 N DURANGO DR.
LAS VEGAS, NV 89149



REMINDERS WHEN VISITING OUR OFFICE

- Plan on being in our office 2 hours.
- Your eyes will be dilated.
- Arrange to have a driver.
- Bring a list of all medications.
- Bring all Insurance cards (Medicare card).
- Bring glasses, contacts and contact case.

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