



**UNIVERSITY  
RETINA**

**UNIVERSITY RETINA & MACULA ASSOCIATES, P.C.**

[www.uretina.com](http://www.uretina.com)

*Specializing in Diseases & Surgery of the Retina, Vitreous, & Macula*

**CONSULT FORM**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Phone:** \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **am/pm**

**Ocular History:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check:** \_\_\_\_\_ *Retinal Consultation (+/- Diagnostic Testing)*  
\_\_\_\_\_ *Diagnostic Testing Only*

**Diagnostic Testing Required**

*Color Photography*

*Fluorescein Angiography (Optional Information: Transit O.D. / Transit O.S.)*

*Optical Coherence Tomography*

*Diagnostic Ultrasonography*

*Other Testing:* \_\_\_\_\_

**Other Notes:** *(Please indicate any are of special interest on drawing below, if desired)*

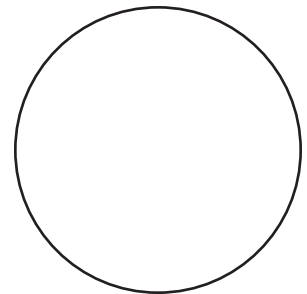
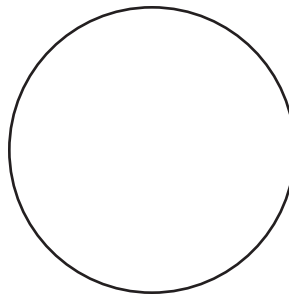
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Requested By:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Tel:** \_\_\_\_\_

**Fax:** \_\_\_\_\_



**Please submit this completed form via email to [referrals@uretina.com](mailto:referrals@uretina.com)  
or fax to (708) 722-4778.**

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