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RETINA CONSULTATION REQUEST

Referring Doctor: _____ **Referring Doctor Phone:** _____

Referring Doctor Fax: _____ **Patient Name:** _____

Patient Phone: _____ **Patient DOB:** _____

Patient Address: _____

Insurance (Primary/ Secondary): _____

Insurance ID number(s): _____

Appointment Date: _____ **Time:** _____ **Please call patient to schedule an appointment**

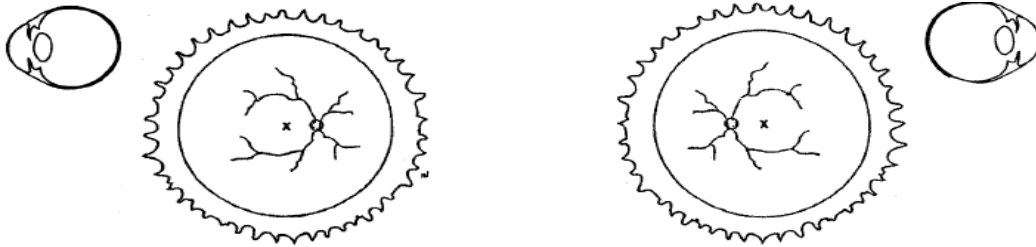
Please call for urgent consultation

Patient will call to schedule an appointment

Visual Acuity: 20/ ___ OD

20/ ___ OS

Retinal Drawing:



Reason for Consultation/ Comments:

If Requesting Ocular Imaging:

Ultrasound Fluorescein/ ICG Angiography OCT (Optical Coherence Tomography) Fundus Photography

Patients need to bring with them to HRA:

- Insurance AND ID-cards
- Last office notes
- Current medication list including eye drops
- Eyeglasses AND sunglasses (all eyes will be dilated)
- A driver