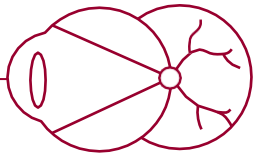
RETINA & VITREOUS CONSULTANTS OF WISCONSIN LTD.

MEDICAL AND SURGICAL TREATMENT OF THE RETINA AND VITREOUS



Jonathan M. Hershey, M.D.
Sharath C. Raja, M.D.
Nicholas H. Tosi, M.D.
Daniel D. Kim, M.D.
Ryan N. Vogel, M.D.

CONSULTATION REQUEST FORM

❑ Dr. Hershey ❑ Dr. Raja ❑ Dr. Tosi ❑ Dr. Kim ❑ Dr. Vogel

❑ Mayfair ❑ St. Lukes's ❑ Seton-Ozaukee ❑ Waukesha ❑ Kenosha

Mr/Mrs/Ms: (Patient) _____

Patient Address:_____

Phone (Home):_____ (Work):_____

Date of Birth: _____ Cell : _____

Medical Insurance: _____

Reason for Consult:_____

_____

_____

VISUAL ACUITY: OD: $\overline{cc}$ OD: $\overline{sc}$

OS: $\overline{cc}$ OS: $\overline{sc}$

This condition has been present for approximately: _____ days / weeks

Please see this patient within the next _____ days / weeks or

❑ Patient already has an appointment on: _____

Doctor's Signature: _____ Date: _____

Doctor's Name: _____
(Please Print)

Please fax this sheet to 414-778-3446 or mail it to

2600 N. Mayfair Road, Suite 901, Milwaukee, Wisconsin 53226

Call 414-778-3455 or 800-837-3937 with any questions