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 ☐ Yes, Co-Manage

☐ Cloudy Capsule/Post-op Problem

☐ Glaucoma Suspect/Workup

☐ LASIK/ICL ☐ Yes, Co-Manage

☐ Cornea

☐ Eyelid/Oculoplastic

☐ Glaucoma Surgeon Consult

☐ Retina

☐ Other _____

☐ Cosmetic Consult

Most recent refraction OD _____

Date _____ OS _____

BVA OD 20/ _____

OS 20/ _____

IOP OD _____ Time _____ ☐ AM ☐ PM

OS _____ ☐ NCT ☐ Goldman ☐ Other

Wellish Vision Institute Location Preference

☐ **Las Vegas - Flamingo**
2110 E Flamingo Rd, Suite 210
Las Vegas, NV 89119

☐ **Las Vegas - Box Canyon**
2555 Box Canyon Dr.
Las Vegas, NV 89128

☐ **Las Vegas - Fort Apache**
6710 S Fort Apache Rd
Las Vegas, NV 891488

☐ **Henderson**
10424 South Eastern Avenue,
Suite 100
Henderson, NV 89052

Please fax this form and notes to:

PROVIDER REFERRALS

Phone: 702-316-4413

PCP & OTHER PROVIDERS

Phone: 702-316-4413

WELLISH VISION INSTITUTE