



C. Armitage Harper, III, M.D.
 Jose A. Martinez, M.D.
 James W. Dooner, M.D.
 Mark Levitan, M.D.
 Peter A. Nixon, M.D.
 Robert W. Wong, M.D.
 Shelley Day, M.D.

WWW.AUSTINRETINA.COM

Please send this form via fax (512-451-2741) in advance of the patient's scheduled appointment, or ask them to bring it on the day of appointment. New patient forms can be filled out and printed from our website. Patient should also bring their distance viewing glasses and all eye drops

PATIENT NAME: _____ DATE EXAMINED: _____

REFERRING DOCTOR: _____

Consult Request

My patient has an appointment for retina consultation with:

appointment date: _____

- C. ARMITAGE HARPER III, M.D.
- JOSE A. MARTINEZ, M.D.
- JAMES W. DOONER, M.D.
- MARK LEVITAN, M.D.

- PETER A. NIXON, M.D.
- ROBERT W. WONG, M.D.
- SHELLEY DAY, M.D.

I am sending this patient to you for assistance with their care. Please evaluate the following problem(s) or condition(s) and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding their care and will resume general care following your consultation.

VA: cc / sc OD: _____ OS: _____ best corrected OD: _____ OS: _____

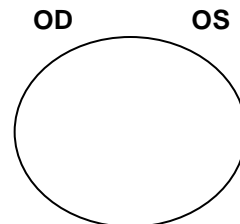
Signed: _____
 [Referring Doctor]

verbal request

Testing Only

diagnosis: _____

- Fundus Photography
- Fluorescein Angiography
- B Scan / Ultrasound (Austin)
- Automated Visual Fields
- Goldmann Visual Fields
- OCT Macular Scan
- OCT Optic Nerve Head Scan
- Research Study Consideration
- Other: _____



Signed: _____

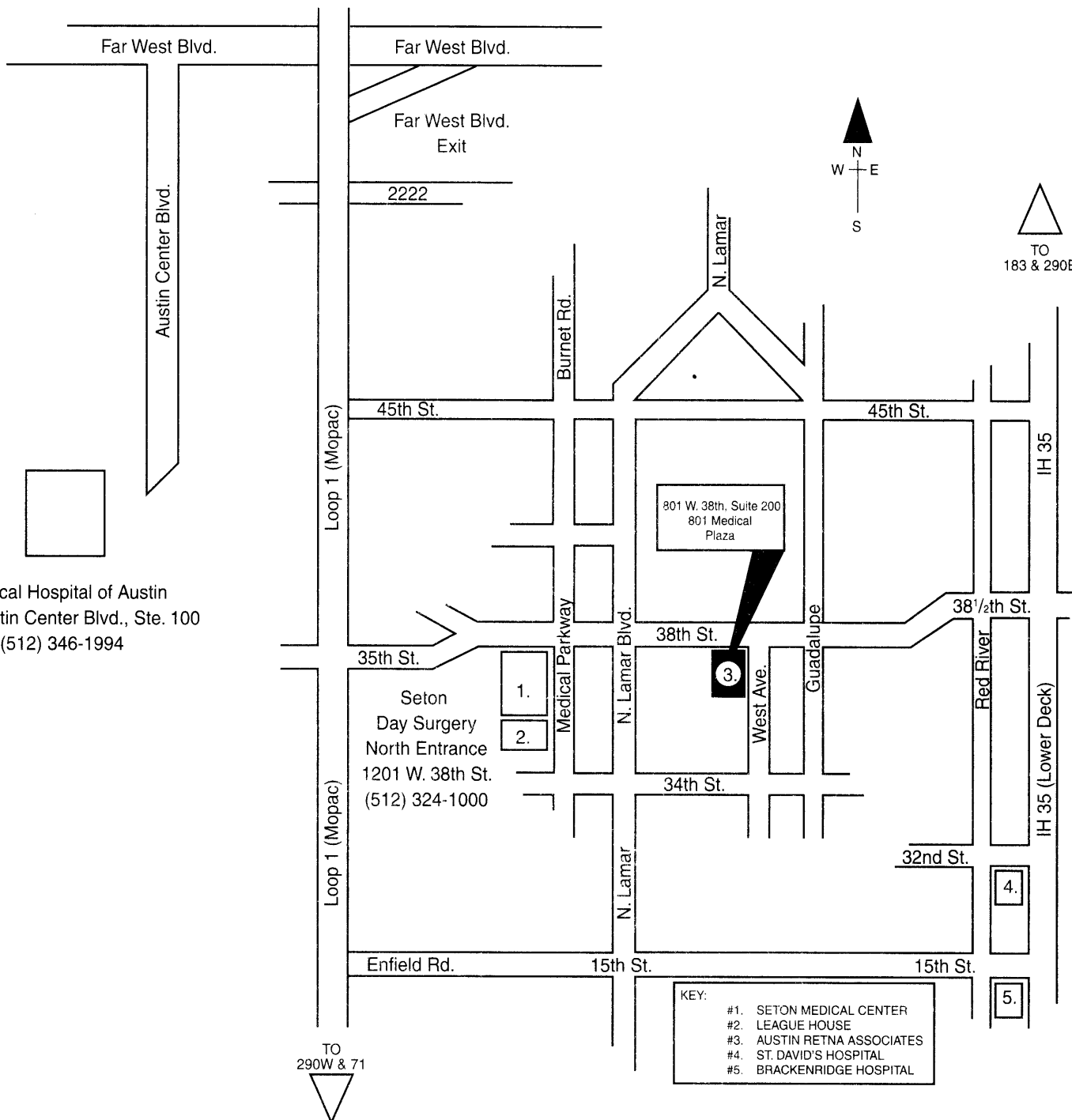
verbal request



To 183



TO 183 & 290E



Surgical Hospital of Austin
 6818 Austin Center Blvd., Ste. 100
 (512) 346-1994

KEY:
 #1. SETON MEDICAL CENTER
 #2. LEAGUE HOUSE
 #3. AUSTIN RETNA ASSOCIATES
 #4. ST. DAVID'S HOSPITAL
 #5. BRACKENRIDGE HOSPITAL

TO
 290W & 71