AUSTIN RETINA
ASSOCIATES
COMPASSIONATE CARE · VISIONARY RESEARCH

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.

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Please send this form via fax (512-383-8335) 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: _____

_____

_____

_____

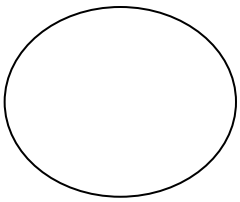
Signed: _____ ☐ verbal request
[Referring Doctor]

☐ *Testing Only*

diagnosis: _____

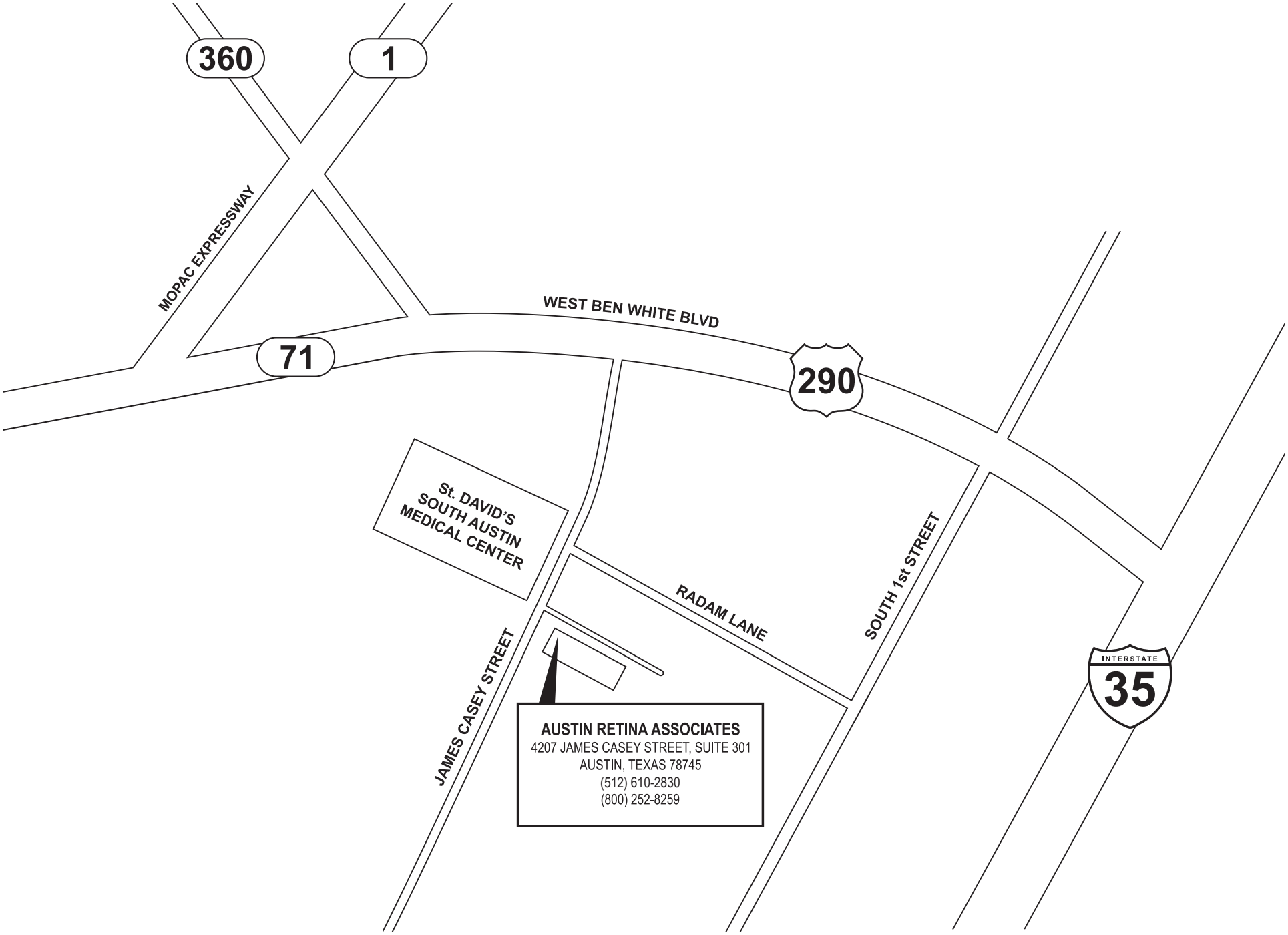
- ☐ Fundus Photography
- ☐ Fluorescein Angiography
- ☐ B Scan / Ultrasound (Austin)
- ☐ Automated Visual Fields
- ☐ Goldmann Visual Fields
- ☐ OCT Macular Scan
- ☐ OCT Optic Nerve Head Scan
- ☐ Research Study Consideration
- ☐ Other: _____

OD **OS**



Signed: _____ ☐ verbal request

4207 James Casey Suite 301 ● Austin TX 78745 ● (512) 610-2830 ● (800) 252-8259 ● Fax (512) 383-8335


360
1
MOPAC EXPRESSWAY
WEST BEN WHITE BLVD
71
290
St. DAVID'S SOUTH AUSTIN MEDICAL CENTER
RADAM LANE
SOUTH 1st STREET
JAMES CASEY STREET
INTERSTATE
35
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