UNIVERSITY RETINA

UNIVERSITY RETINA & MACULA ASSOCIATES, P.C.

www.uretina.com

Specializing in Diseases & Surgery of the Retina, Vitreous, & Macula

CONSULT FORM

Patient Name: ________________________ **DOB:** ___________________

Patient Phone ________________________

Appointment Date: _____ / _____ / 20_____ **Time:** _______ **am/pm**

Ocular History:

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____

Please check: ____ *Retinal Consultation (+/- Diagnostic Testing)*

____ *Diagnostic Testing Only*

Diagnostic Testing Requested

Color Photography

Fluorescein Angiography (Optional Information: Transit O.D. / Transit O.S.)

Optical Coherence Tomography

Diagnostic Ultrasonography

Other testing ____

Other Notes: *(Please indicate any are of special interest on drawing below, if desired.)*

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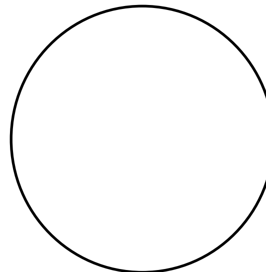

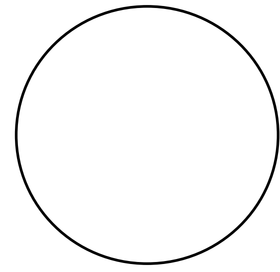

Requested By: _____________________

Date: ______________________________

Tel: _______________________________

Fax: _______________________________

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Oak Forest, IL 60452
708-687-2222

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