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: _____ **Time:** _____ **am/pm**

Ocular History:

_____

_____

_____

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

_____ *Diagnostic Testing Only*

Diagnostic Testing Required

Color Photography

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

Optical Coherence Tomography

Diagnostic Ultrasonography

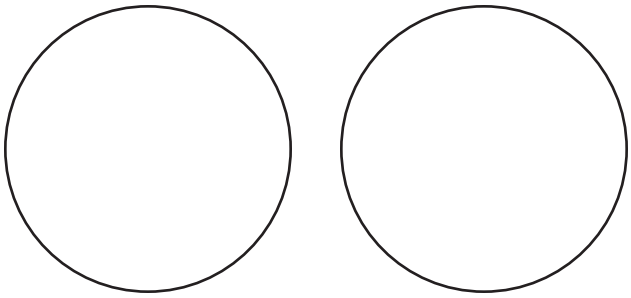
Other Testing: _____

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

_____

_____

_____



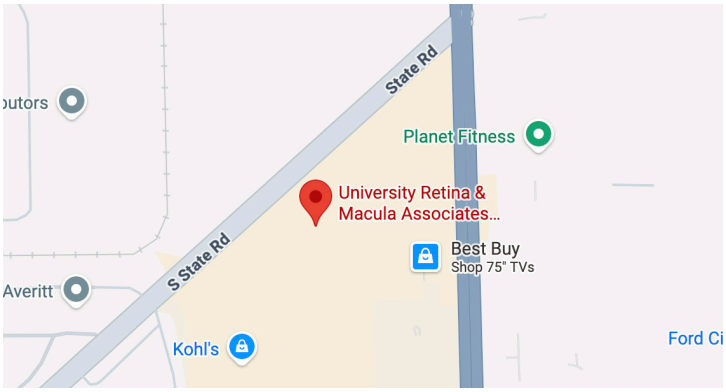
Requested By: _____

Date: _____

Tel: _____

Fax: _____

Please submit this completed form via email to referrals@uretina.com or fax to (708) 722-4778.

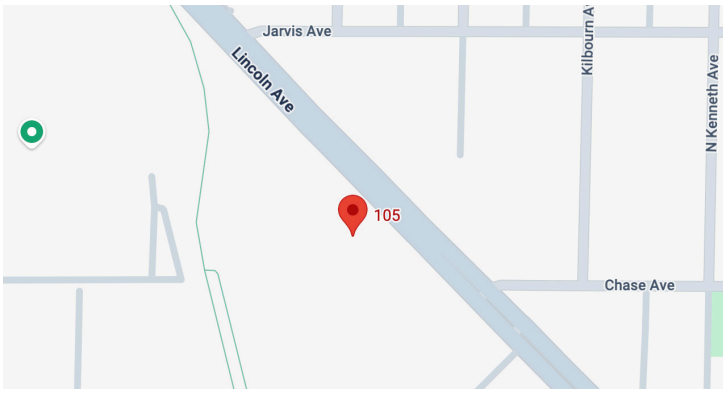


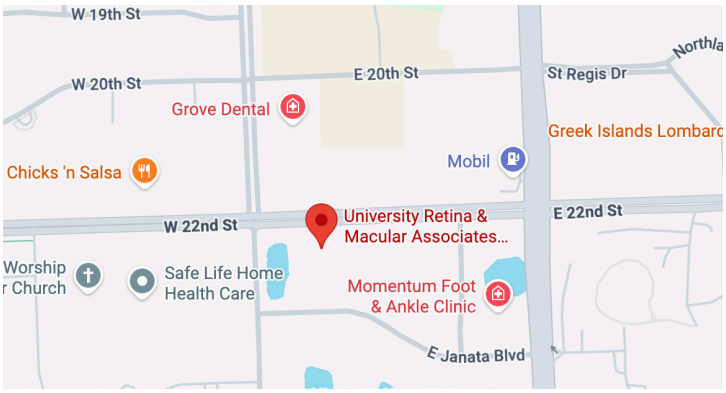
Bedford Park

7456 S. State Rd.
Suite 103
Bedford Park, IL 60638
(708) 424-6500

Lemont

15947 W. 127th St.
Suite E
Lemont, IL 60439
(630) 410-8357



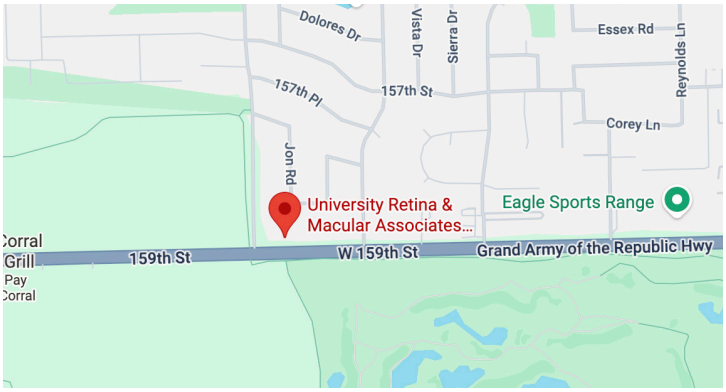


Lincolnwood

7366 Lincoln Ave.
Suite 105
Lincolnwood, IL 60712
(708) 575-9829

Lombard

1 E. 22nd St.
Suite 100
Lombard, IL 60148
(331) 777-2300



Oak Forest

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