Dear

PLEASE SEE:

Name:_____

DOB: _____ Phone number:_____

Address:_____

_____

FOR:

❑A RETINAL ISSUE: ❑CATARACT/REFRACTIVE ❑OTHER

❑BRVO/CRVO

❑Age related macular degeneration

❑Diabetic Retinopathy /screening

❑Other

Clinical Details:_ _____VA_____

_____IOP_____

❑Requires OCT

❑Requires intravitreal treatment

_____

_____

FOR APPOINTMENTS:

Phone: (03) Fax: (03)

Name:_____ Date:_____

Signed:_____Provider Number:_____

PRACTICE ADDRESS: