



**Longmont Office:**  
 1400 Dry Creek Drive  
 Longmont, CO 80503  
 P: 303.772.3300  
 F: 303.682.3380

**Lafayette Office:**  
 300 Exempla Cir, Ste. 120  
 Lafayette, CO 80026  
 P: 303.772.3300  
 F: 303.682.3380

**Boulder Office:**  
 3000 Center Green Dr., Ste. 250  
 Boulder, CO 80301  
 P: 303.772.3300  
 F: 303.682.3380

**Greeley Office:**  
 1616 15<sup>th</sup> Street  
 Greeley, CO 80634  
 P: 303.772.3300  
 F: 303.682.3380

## Request for Ophthalmic Consultation

Please FAX to: 303-682-3380

Referring Physician \_\_\_\_\_ Office: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician Phone \_\_\_\_\_ Referring Physician Fax \_\_\_\_\_

Referring Physician Contact Person \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patients Phone # \_\_\_\_\_

Patient needs to be seen: **\* Emergently \***  **Today** **OR**  **Within 24 hours**  
 Within 2 to 3 days  Within 1 week  
 Within \_\_\_\_ weeks  Next available (no time restrictions)

Insurance Carrier: \_\_\_\_\_

*\*\* Please provide copies of the current insurance cards if available.*

- To:  **Retina Consultants**  **Glaucoma Consultants**  **Other Specialists**
- Elisha Tilton, MD
  - Justin Kanoff, MD
  - Matthew Manry, MD
  - Carl Noble, DO
  - Micah Rothstein, MD (& Cataract)
  - Anjali Sheth, MD (& Cataract)
  - Mansi Parikh, MD (& Cataract)
  - Joel Meyers, MD (Cataract/Oculoplastic )
  - Aimee Verner, MD (Cornea, LASIK, Cataract)
  - Robert Krone, OD (Medical Contacts)
  - Jane Wolford, OD (Dry Eye)
  - Melissa Burton, OD (Medical Contacts)
  - Scott Bartlett, OD (Primary Care)

**MUST INCLUDE: Brief description of reason for referral, most recent chart notes, registration/demographics sheet, PLUS any relevant testing done in your office (i.e. visual fields, etc.)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Consider treatment as appropriate. I look forward to receiving your opinion and advice regarding the care of this patient, and will resume general care following your consultation.
- I prefer to co-manage this patient [Cataract or LASIK]
- I request that you refer to another specialist if additional problems/conditions are discovered upon evaluation.

Signed \_\_\_\_\_  
 [Referring Doctor]

FAX (303)682-3380