



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 15th Street
Greeley, CO 80634
P: 303.772.3300
F: 303.682.3380

Request for Ophthalmic Consultation

Please FAX to: 303-682-3380

Referring Physician _____ 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 Micah Rothstein, MD (& Cataract) Joel Meyers, MD (Cataract)
 Justin Kanoff, MD Anjali Sheth, MD (& Cataract) Aimee Verner, MD (Cornea, LASIK, Cataract)
 Matthew Manry, MD Mansi Parikh, MD (& Cataract) Diane Siegel, MD (Cataract)
 Carl Noble, DO Adrianna Jensen, MD (Oculoplastics)

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