



**Alexander Izad, M.D., F.A.C.S.**  
 Vitreoretinal Disease and Surgery  
 1530 N. 7<sup>th</sup> St, Suite 502  
 Terre Haute, IN 47807  
 Tel: (812) 281-2608 Fax: (812) 281-2610

**RETINA CONSULTATION REQUEST**

**Referring Doctor:** \_\_\_\_\_ **Referring Doctor Phone:** \_\_\_\_\_

**Referring Doctor Fax:** \_\_\_\_\_ **Patient Name:** \_\_\_\_\_

**Patient Phone:** \_\_\_\_\_ **Patient DOB:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_

**Insurance (Primary/ Secondary):** \_\_\_\_\_

**Insurance ID number(s):** \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_  **Please call patient to schedule an appointment**

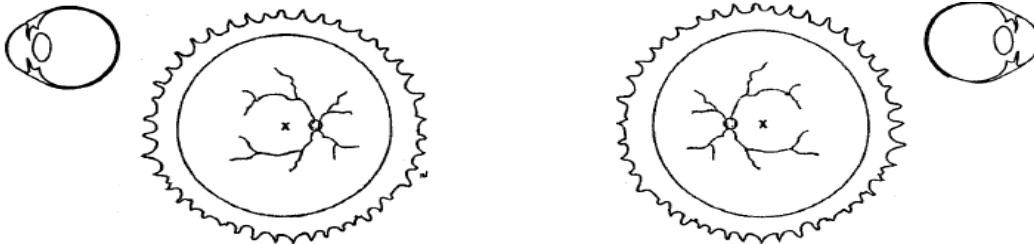
*Please call for urgent consultation*

**Patient will call to schedule an appointment**

**Visual Acuity:** 20/ \_\_\_ OD

20/ \_\_\_ OS

**Retinal Drawing:**



**Reason for Consultation/ Comments:**

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**If Requesting Ocular Imaging:**

Ultrasound  Fluorescein/ ICG Angiography  OCT (Optical Coherence Tomography)  Fundus Photography

**Patients need to bring with them to HRA:**

- Insurance AND ID-cards
- Last office notes
- Current medication list including eye drops
- Eyeglasses AND sunglasses (all eyes will be dilated)
- A driver

**Our Office Location:**

We are located on the 5<sup>th</sup> floor of Union Hospital's Professional Office Building.

1530 N 7<sup>th</sup> St., Suite 502

Terre Haute, IN 47807



**PLEASE FAX THIS FORM TO THE NUMBER ABOVE & GIVE THIS FORM TO THE PATIENT TO BRING TO OUR OFFICE. THANK YOU.**