RETINA INSTITUTE OF THE CAROLINAS
& THE MACULAR DEGENERATION CENTER

Nasi Samiy, MD □
Arman Farr, MD □
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Consultation Request

Date: _____ Location Requested: □ Charlotte □ Matthews □ Gastonia □ Rock Hill

Referring Provider Information

Name: _____ Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Patient Demographic Information

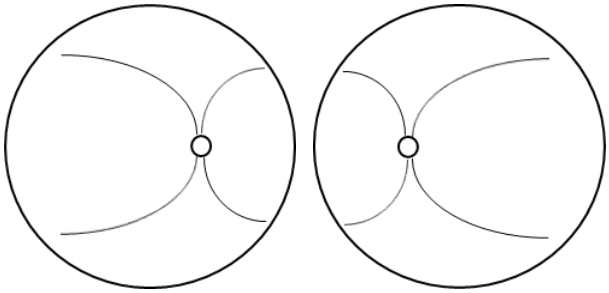
Name: _____D.O.B_____ Gender: _____

Patient Address: _____

Zip code: _____Phone number(s): _____

Primary Insurance: _____(Please send front and back copies of insurance card)

Briefly state referral reason:



Visual acuity:

OD: 20/____

OS: 20/____

Urgent consultation for:

□ Retinal Detachment

□ Retinal Tear

□ Endophthalmitis

□ Vitreous Hemorrhage

□ Other:_____

Routine consultation for:

□ Diabetic Retinopathy

□ Dry AMD

□ Epiretinal Membrane

□ Macular Hole

□ Other:_____

□ Vein Occlusion

□ Choroidal Nevus

□ Uveitis

□ Neovascular Glaucoma

Please include chart note when faxing referral and call office for urgent referrals.
Charlotte P:(704)332-1700 F:(704)347-2710 / Matthews P:(704)238-9900 F:(704)238-9800
Rock Hill P:(803)323-2020 F:(803)329-7897 / Gastonia P:(704)864-7722 F:(704)864-7882