



CONSULTATION REQUEST FORM

Please Fax Form to (727) 499-5277 or Email Form to odreferral@eyespecialist.com

Today's Date: ____/____/____

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Male Female

Cell: (____) ____ - _____ Home: (____) ____ - _____ Email: _____

Address: _____

OFFICE INFORMATION

Referring Physician: _____ Phone: _____

Office Address: _____

REFERRAL DETAILS

Primary: Cataract/Refractive Cornea Glaucoma Retina Oculoplastics General

Secondary: Cataract/Refractive Cornea Glaucoma Retina Oculoplastics General
(if applicable)

If you wish to schedule with a specific doctor, please select your request below:

Cataract/Refractive: Stephen M. Weinstock, M.D. Robert J. Weinstock, M.D. Neel R. Desai, M.D.

Cornea: Neel R. Desai, M.D.

Glaucoma: Jeffrey S. Schwartz, M.D. Amy Z. Martino, M.D. R. Taylor Davis, M.D.

Retina: Leonard S. Kirsch, M.D. Richard J. Hairston, M.D. Janie Ho, M.D. Sejal Shah, M.D.

Oculoplastic: Brandon C. Clair, M.D. Stacia H. Goldey, M.D.

General Consult: Winston T. Cope, MD Lewis I. Apter, MD Jory D. Williams, MD James A. Roberts, MD

Urgent Not-Urgent Do not Contact Patient

Exam Notes: Provided with Referral Sent Separately- Via Email Via Fax

Comments: _____

*Please note that your patient may schedule with another provider in the same specialty based on insurance, scheduling conflicts, and patient's preference.

Did you know you can submit you referral online? It's quick, easy and HIPAA secure.

Go to www.refereyepatient.com in your internet browser to get started.