THE EYE INSTITUTE OF WEST FLORIDA

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** ☐ **Pediatrics** ☐ **Adult Strabismus** ☐ **General**

Secondary: ☐ **Cataract/Refractive** ☐ **Cornea** ☐ **Glaucoma** ☐ **Retina** ☐ **Oculoplastics** ☐ **Pediatrics** ☐ **Adult Strabismus** ☐ **General**
(if applicable)

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

Cataract/Refractive:	☐ Stephen M. Weinstock, MD	☐ Robert J. Weinstock, MD	☐ Neel R. Desai, MD	☐ Chad D. Hummel, MD
Cornea:	☐ Neel R. Desai, MD	☐ Joshua R. Roe, MD		
Glaucoma:	☐ Amy Z. Martino, MD	☐ Nora L. Cothran, OD	☐ David K. Talley, OD	
Retina:	☐ Leonard S. Kirsch, MD	☐ Richard J. Hairston, MD	☐ Janie Ho, MD	☐ Sejal Shah, MD
Oculoplastics:	☐ Brandon C. Clair, MD	☐ Stacia H. Goldey, MD		
Pediatrics:	☐ Julia M. Byrd, MD			
Adult Strabismus:	☐ Julia M. Byrd, MD			
General Consult:	☐ Winston T. Cope, MD	☐ Lewis I. Apter, 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.

You can submit your referral with our HIPAA secure form at:
www.refereyepatient.com
Main Phone No: 727-581-8706

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