Patient referral request form

Alexander Kuley, M.D.

(Retina & Comprehensive Ophthalmology)

513-922-1550 / 513-922-1572 (fax)

Referring Dr. / Practice: _____

Patient name:_____

Patient phone #:_____

Date of Birth:_____

Urgency: call office for same or next day appointments.
Otherwise:
_____Next available
_____Within 1 week
_____Within 1 month

Medical Insurance (required):_____

Please include a copy of the **medical insurance** card if possible.

Patient consultation requested for:

___Cataract evaluation	___Retinal tear / detachment	___ PVD
___Glaucoma evaluation	___Macular degeneration. Wet / dry	___Vitreous hemorrhage
___Tearing	___Diabetes: NPDR	___Uveitis / Iritis
___ Secondary cataract	___Diabetes: PDR	___CRAO
___ Corneal evaluation	___Macular edema	___Papilledema
___ Chalazion	___BRVO / CRVO	___Lattice / myopia / holes
___CSR	___Retinal dystrophy	___VMT
___Nevus	___ other: _____	

Notes for Dr. Kuley:

_____

_____

_____

Best corrected visual acuity: OD _____ OS _____

Referring Doctor's signature: _____

Please fax to: 513-922-1572
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513-922-1550