PATIENT CONSULTATION FORM

EYE SPECIALISTS OF TEXAS

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American Board of Ophthalmology

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Date: _____

Referring Doctor: _____ Phone #: _____ Fax #: _____

This letter serves to introduce: _____

Patient's telephone number: _____

Reason for Consultation / Pertinent Clinical History:

_____

_____

_____

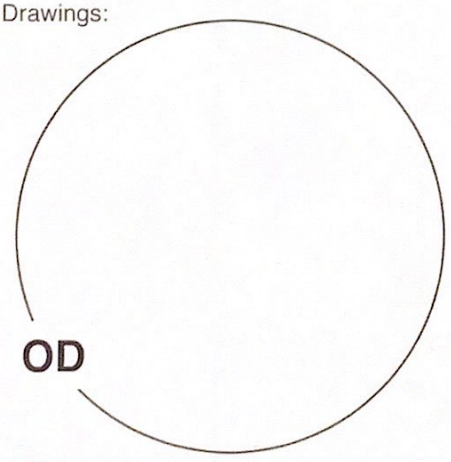
_____

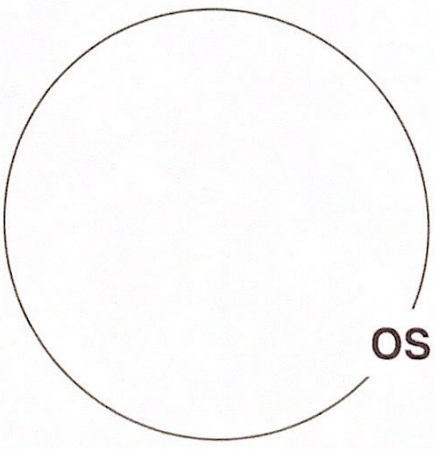
Findings today. Please fill in as appropriate:

V OD _____ IOP OD _____

A OS _____ OS _____

Drawings:





PLEASE INDICATE CO-MANAGEMENT PREFERENCE _____

ANY SPECIAL STUDIES REQUESTED _____

Please Fax This Form / Send With Patient. Thank You.

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