



Please attach patient demographic information and insurance card.

Patient Information:

Name: _____

Date of Birth: ____/____/____

Phone Number: _____

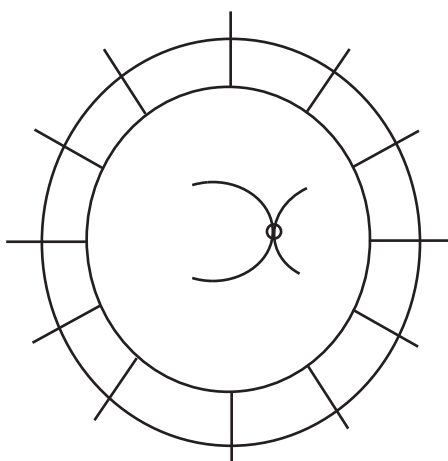
Date: ____/____/____

Referral: (must call for emergencies and urgencies)

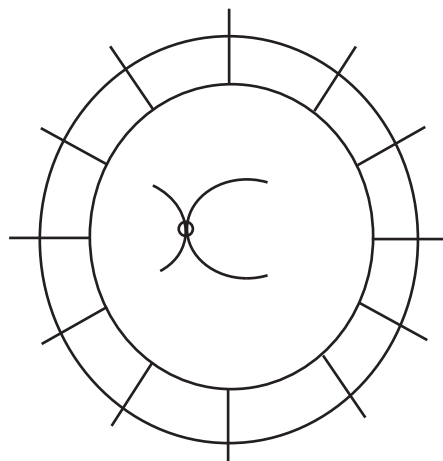
- ☐ Emergency (within 24 hours) ☐ 2 - 4 weeks
☐ Urgent (24 - 48 hours) ☐ When convenient
☐ 1 - 2 weeks

Referring Diagnosis: OD OS OU _____

- | | | | |
|---|--|--|---|
| ☐ Wet AMD | ☐ Posterior Vitreous Detachment | ☐ Artery/Vein Occlusion | ☐ Diabetic Retinopathy |
| ☐ Dry AMD | ☐ Retinal Tear | ☐ Macular Edema | ☐ Uveitis |
| ☐ Nevus/Melanoma | ☐ Retinal Detachment | ☐ Macular Hole | ☐ Disc Edema |
| ☐ Cataract Clearance | ☐ Peripheral Hole/Lattice | ☐ Epiretinal Membrane | ☐ Plaquenil Use |



OD



OS

Referring Physician Information:

Name: _____

Office Number: _____

Appointment Date: ____/____/____

Appointment Time: _____

Preferred Appointment with:

- | | |
|--|---|
| ☐ Mark A. Gersman, MD | ☐ Stephen M. Conti, MD |
| ☐ Robert E. Wenz, MD | ☐ Richard E. Wyszynski, MD |
| ☐ Stephen R. Kaufman, MD | ☐ Christopher M. Bair, MD |
| ☐ Sophia I. Pachydaki, MD | ☐ Baha El Khatib, MD |
| ☐ _____ | |

The patient will: ☐ call Vitreo-Retinal Consultants, Inc. to schedule.
☐ wait for Vitreo-Retinal Consultants, Inc. to call and schedule.

Canton

4676 Douglas Circle NW, Canton, OH 44718
Phone: 800-438-1169 ♦ Fax: 330-494-0276

Canfield

45 Manor Hill Dr., Ste. 200, Canfield, OH 44406
Phone: 800-742-7268 ♦ Fax: 330-533-8930

Hermitage

3135 Highland Rd., Ste. A, Hermitage, PA 16148
Phone: 800-476-3129 ♦ Fax: 724-346-4183

Mentor

8140 Norton Pkwy., Ste. 230, Mentor, OH 44060
Phone: 800-226-1738 ♦ Fax: 440-918-7440