East Carolina Retina
CONSULTANTS

Consultation Request

2501A Stantonsburg Rd
Greenville, NC 27834
EastCarolinaRetina.com

office 252.758.2402
toll free 800.849.8459
fax 252.758.2762

Patient Name:_____

DOB:_____ SSN:_____

Address:_____ Zip :_____

Telephone # H: _____ C: _____

Insurance ID: _____

Referring Physician:_____ Phone#: _____

Form Faxed By: _____ Fax#: _____

Emergent ☐	**Urgent** ☐	**Non-Urgent** ☐
24 hrs ☐	**This Week** ☐	**2 Weeks** ☐
48 hrs ☐	**Next Week** ☐	**1st Available** ☐

Dear Dr. Van Houten & Associates,

I am sending this patient to you for assistance with his/her care. Please evaluate this patient's problem(s) or condition(s) [describe]:

_____

_____

_____

_____

_____

and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient, and will resume general care following your consultation.

Signed:_____ **Date:**_____

Referring Physician's Signature

Please fax this form along with the patient's **most recent medical notes** and **insurance cards** to 252-758-2762 and we will return this form to you with an appointment date and time. Please tell the patient our office will call him/her at home with an appointment time within 5 business days depending on the urgency of the appointment.

APPT DATE:_____ **APPT TIME:**_____ **ECRC EMP:**_____

This patient ____ Failed to Show ____ Canceled ECRC Emp:____