Barry A. Mandell, M.D. Adam T. Lipman, M.D.

Consultation Request

Please call to schedule all appointments (757)227-4300

Please fax this form to (757)486-3125 or scan and email to mail@mandellretina.com

Other forms to send: Patient demographics, proof of insurance, last exam note

This section to be filled out by referring practice

Date
_________ / _________ / ________

Patient Information

____
last name first name

____
phone number date of birth

Referring Doctor Information

Physician: ____________________
Contact Person: ____________________
Office Phone: ____________________
Office Fax: ____________________

Referring diagnosis ___________________________________

Right Eye ________ Left Eye

Services Requested (check an option or write in)

Type of appointment

_______________ Emergency (today)
_______________ Emergency (tomorrow)
_______________ Urgent (3-4 days)
_______________ Routine

Please Note: All referrals must be accompanied by a phone call, especially in the setting of an emergency.

Received by MRC Staff