# New York Retina

## Consultants

Alan R. Dayan, MD
Steven A. Agemy, MD

# Consultation Request

*LOCATIONS:*

*Manhattan:* *310 E 14th St., Suite 419*
*New York, NY 10003*

*Queens:* *112-03 Queens Blvd. Suite 206*
*Forest Hills, NY 11375*

*Phone #:* *(212) 677-2000*

*Fax #:* *(212) 353-5754*

*Website:* retinadocsnyc.com

*I am referring this patient to you for evaluation and possible treatment. The patient will return back to our office to continue his/her general eye care after your recommendation.*

*REFERRING DOCTOR INFORMATION*

*NAME*_____ *PHONE #*_____

*ADDRESS*_____ *FAX#*_____

*PATIENT NAME:*_____

*PATIENT PHONE NUMBER:* _____

*D.O.B.*_____ *VA: OD 20/*_____ *VA: OS 20/*_____

*HISTORY AND DIAGNOSIS:*_____

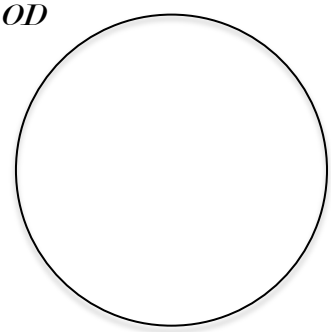
_____

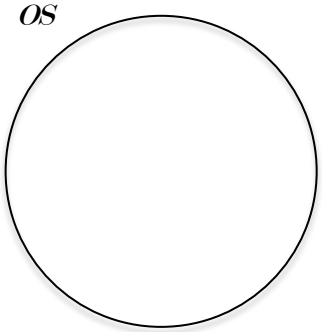
_____

*SPECIAL INSTRUCTIONS:*_____

_____

*OD* *OS*





***PATIENT INSTRUCTIONS:***

1. *Please bring this form with you to our office.*
2. *Your eyes will be dilated, and we advise you have a driver.*
3. *You will be in our office one to two hours.*
4. *Please bring current insurance and picture ID with you.*
5. *If you need a referral from your insurance plan, please be sure to obtain one prior to your visit.*

*Appointment Date:*_____

*Appointment time:*_____

*Location:* *Manhattan* *Queens*