Dartmouth Health

Dartmouth Hitchcock Medical Center

Phone: (603) 650-5123
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Ophthalmology

Reason for Consult _____

_____

_____

_____

_____

_____

_____

Subspecialty Requested (check one): ❑ Cataract ❑ Cornea ❑ Glaucoma ❑ Orthoptics ❑ Pediatrics ❑ Plastics ❑ Retina ❑ Uveitis ❑ Neuro-ophthalmology

Specific Provider (if known)_____

Timeline: ❑ Medically Urgent (48 hours-2 weeks) ❑ Next Avaialable ❑ Other: _____

Notes associated with this request:

❑ Summary Letter _____

❑ Pertinent eye notes _____

❑ Ancillary test _____

❑ Eye Medications _____

OFFICE USE ONLY:

Appointment made w/Dr._____ on _____ at_____