

RETINA-VITREOUS CONSULTANTS

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Practice Limited To Diseases and Surgery of the Retina and Vitreous

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Macular Degeneration Center of New Jersey
Institute For Treatment of Diabetic Eye Disease

Request for Consultation

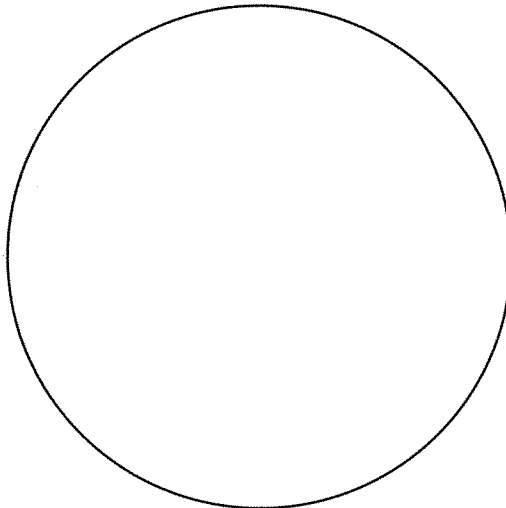
Patient's Name: _____

Patient's Phone #: _____ **Request Date:** _____

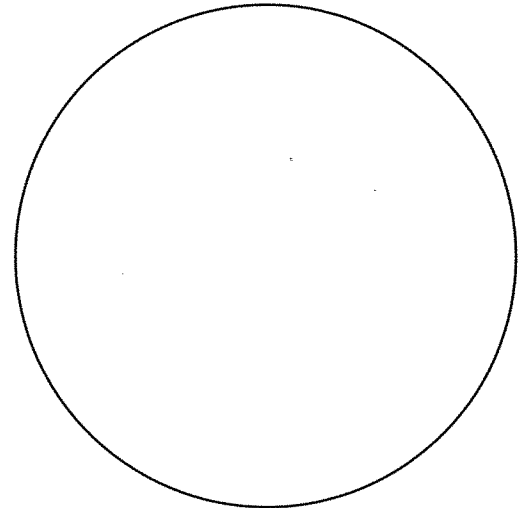
Referring Physician: _____ **Diagnosis:** _____

Reason for Consult: _____

OD



OS



Primary Eye to be Studied: OD OS OU

Other Instructions:

INSTRUCTIONS TO PATIENT:

PLEASE BRING THIS FORM WITH YOU TO OUR OFFICE. YOUR EYES WILL BE DILATED AND WE ADVISE THAT YOU HAVE A DRIVER. YOU WILL BE IN OUR OFFICE A MINIMUM OF TWO HOURS. IF YOU NEED A REFERRAL FROM YOUR INSURANCE PLAN, PLEASE BE SURE TO OBTAIN ONE PRIOR TO YOUR VISIT.