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Referral for Ophthalmology Consultation

Patient Name: _____ Client Name: _____

Referred by Dr.: _____ Hospital Name: _____

Description of problem: including presenting symptoms, duration and progression.

Tentative Diagnosis: _____

Systemic conditions: _____

Medications used	Date	Response

Diagnostic Tests	Date	Result

Please send or FAX copies of any test results (including blood panels) performed within the past six months. Our IDEXX number is 1709.

