Mid Michigan Retina, PLC

Ashim Aggarwal, MD

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REQUEST FOR CONSULTATION

PATIENT INFORMATION (Please Print)

Name: ____ Date:__________________

Date of Birth: _______________ Age: ______ ☐ M / ☐ F

Address: ____
Street City State Zip

Phone: Home (_______) __________________ Work (_______) ___________________

INSURANCE INFORMATION: ____

Dear Dr. Aggarwal,

I am sending the above-referenced patient to you for assistance with his / her care. Please evaluate this patient's problem(s) or condition(s) as listed below, and consider treatment as appropriate.

DIAGNOSIS:____

____

____

Doctor's Name: ____

Address: ____
Street City State Zip

Phone: (_______) ________________ Fax: (_______) __________________

Doctor's Signature:_______________________________________ Date:______________________

I look forward to receiving your opinion and advice regarding care of this patient, and will resume this patient's care following your consultation.

I am / am not willing to receive your note via fax at the above fax number

Appointment: Date _______/_______/________ Time: ______:________am/pm

NOTE: PLEASE FAX THIS REQUEST TO (517) 574-5852 IN ADVANCE OF YOUR PATIENT'S APPT.