



REQUEST FOR CONSULTATION

Patient Information:

Patient Name: _____ DOB _____

Patient's Phone: _____ Patient's MRN: _____

Patient's Address: _____

Insurance*: _____

**HMO patients please note, an approved referral is required at the time of your visit.*

Referring Doctor: _____

Doctor Phone: _____ Doctor Fax _____

Reason for Consult:

I look forward to receiving your opinion and advice regarding care of this patient and will resume general care following your consultation or once the patient is stable.

Referring Doctor Signature _____

For Appointment:

Call: (614) 293-8116

Records: (614) 293-4186

Fax: (614) 293-5315

Appointment Details:

Eye & Ear Institute Dublin

Date: _____

Time: _____ AM PM

Referral Instructions:

- Emergency
- Second Opinion Only
- Consultation
- Exam & Treatment

Additional Information Included:

- Last exam note(s) w/ diagnosis
- Visual Field/ OCT / HRT
- MRI Report/Film
- Other visual test _____

Select Specialist (Please note that some physicians multi-specialize):

Cornea/Cataracts

- Andrew Hendershot, MD (Comprehensive)
- Rebecca Kuennen, MD (LASIK)
- Richard Lembach, MD (LASIK)
- Thomas Mauger, MD

Comprehensive Ophthalmology/Cataracts

- David Castellano, MD (LASIK)
- Amit Tandon, MD (LASIK)

Glaucoma/Cataracts

- Gloria Fleming, MD
- Shelly Gupta Jain, MD (Comprehensive)
- Frederick Kapetansky, MD
- Andrea Sawchyn, MD
- Mark Slabaugh, MD
- Paul Weber, MD

Oculoplastics

- Raymond Cho, MD

Neuro-Ophthalmology

- David Hirsh, MD (Comprehensive)
- Steven Katz, MD (Oculoplastics, Orbital Surgery)
- Abbe Craven, MD (Oculoplastics, Orbital Surgery)

Retina

- Colleen Cebulla, MD, PhD (Ocular Oncology)
- Frederick Davidorf, MD (Ocular Oncology)
- L. Carol Laxson, MD, PhD
- Alan Letson, MD
- Matthew Ohr, MD
- Michael Wells, MD

Optometry

- W. Randall McLaughlin, OD, MS (Contact Lenses)
- John Melnyk, OD, PhD (Anterior) - Carepoint East only
- Barbara Mihalik, OD
- Chantelle Mundy, OD (Contact Lenses)
- Stephanie Pisano, OD (Contact Lenses, Low Vision)

Fax completed form to (614) 293-5315 in advance of the appointment

OSU HAVENER EYE INSTITUTE

915 Olentangy River Road, Suite 5000
Columbus, Ohio 43212



THE OHIO STATE UNIVERSITY

WEXNER MEDICAL CENTER

REQUEST FOR CONSULTATION

Referring To:

Doctor Name _____ Subspecialty _____

Phone _____ Fax _____

Address _____

City _____ ST _____ Zip _____

Referring From:

Doctor Name _____ Subspecialty _____

Phone _____ Fax _____

Address _____

City _____ ST _____ Zip _____

Patient Information:

Patient Name _____ DOB _____

Phone _____ MRN _____

Address _____

City _____ ST _____ Zip _____

Reason for Consult:

[Empty box for Reason for Consult]

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