



Ophthalmic Consultant
of New York

Nikola Ragusa, MD

Diseases & Surgery of the Eye

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Consultation Referral Form

Referring Doctor: _____ Date: _____

Phone: _____ Fax: _____

Patient's Name: _____

Phone: _____ DOB: _____

Indication for Consult:

- | | |
|---|--|
| <input type="checkbox"/> Blurry or Decreased Vision | <input type="checkbox"/> Surgical Consultation |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Irritation / Discomfort | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Dry Eye / Allergies | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Other _____ | |

To our patients:

Please bring this form with you to your appointment.
Please notify us if you are unable to keep your appointment.