



# Consultation Fax Form

[www.TNRETINA.com](http://www.TNRETINA.com)

Date: \_\_\_\_\_

Please fax this form and any clinical notes or medication lists to (888) 818-0952 **If an urgent appointment is needed, please call our Provider Line at (615) 997-0055 to schedule.**

**Appointment has already been scheduled.**

Date/Time: \_\_\_\_\_

**Appointment needs to be scheduled by Tennessee Retina**

Patient Name: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Patient Alt. Phone: \_\_\_\_\_

Patient Birthdate: \_\_\_\_\_

\*Insurance: \_\_\_\_\_

\*ID #: \_\_\_\_\_

### Tennessee Retina Physician:

- Everton L. Arrindell, M.D.
- Carl C. Awh, M.D.
- Brandon G. Busbee, M.D.
- Bernard Dib, M.D.
- Hesham K. Gabr, M.D.
- Jay P. Glover, M.D.
- Sarah Kamal, M.D.
- Brigid K. Marshall, M.D.
- Franco M. Recchia, M.D.
- David A. Reichstein, M.D.
- Eric W. Schneider, M.D.
- Marcus J. Solomon, M.D.
- Akshay S. Thomas, M.D.
- R. Trent Wallace, M.D.
- Lauren M. Wright, M.D.
- Mitchell T. Allphin, M.D., *Fellow*
- Ogul E. Uner, M.D., *Fellow*
- Any Physician

### Tennessee Retina Location:

- Nashville
- Bowling Green
- Clarksville
- Columbia
- Cookeville
- Dickson
- Franklin
- Hendersonville
- Hermitage
- Murfreesboro

### Diagnosis or Reason For Consultation:

- |   | OD:                      | OS:                      |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> Diabetic Exam- EVAL / NPDR / PDR | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Epiretinal Membrane              | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Macular Degeneration- wet / dry  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Macular Edema                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Retinal Detachment               | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> PVD, Flashes, Floaters           | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Vascular Occlusion               | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____                      |                          |                          |

### Referring Physician Information:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Additional Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Non-Emergent Consultation Requests may also be submitted online at [www.TNRETINA.com](http://www.TNRETINA.com)**

If TNR is scheduling an appointment from this form, we will contact your patient within 2 business days.