Thom
Eye and Laser Clinic
We Focus on You

REQUEST FOR CONSULTATION

Referring Physician's Information:

Referring Physician's Name:_____ Date:_____

Clinic Name:_____

Address:_____

City:_____State_____Zip Code:_____

Telephone:_____Fax:_____Contact:_____

Patient Information: Gender: ☐ Male ☐ Female

Name: First_____Middle_____Last_____

Address:_____

City:_____State_____Zip Code:_____

Home Number:_____Cell_____Work_____

Insurance: Primary_____Secondary_____

Requested Appointment:

_____

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Thank you for allowing us to participate in caring for your patient. Please fax or mail this form to the provided number/address below along with any notes and test results pertaining to the referral. We will contact the patient within 24 business hours.

Thom Eye & Laser Clinic
2601 University Dr. South
Fargo, ND 58103
Phone: 701-235-5200 Fax: 701-237-0927

This form can also be completed online! www.thomeye.com