PACIFIC RETINA CENTER
JAMISON R. RIDGELEY, MD

please fax or email this form to:
425-988-0168 or info@seattleretinaspecialist.com

1412 SW 43rd St., STE 206
Renton, WA 98057
p. 253-236-5720

Monday - Friday 8am to 5pm

REQUESTED APPOINTMENT TIME FRAME

☐ Immediately ☐ Within One Month ☐ When Patient Prefers
☐ Within One Week ☐ Other:_____

PATIENT INFORMATION

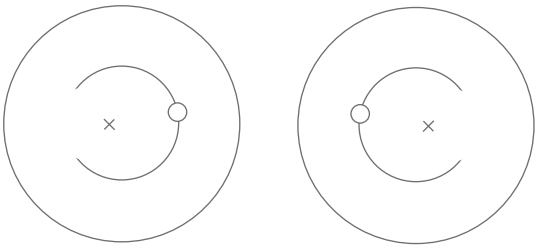
Patient's Name (First, Middle, Last)			Sex ☐ Male ☐ Female
Address			County
City	State	ZIP code	Birth Date (MM/DD/YYYY)
Preferred Phone ☐ cell ☐ home	Alternate Phone ☐ cell ☐ home	Patient's Email Address	
Patient Insurance (please also attach copy of insurance card)		Name, Relationship & DOB of Primary Insured (if not patient)	
Insurance Type ☐ HMO ☐ PPO ☐ Other			

REASON FOR CONSULT

Appointment Type

☐ Wet AMD	RT	LT
☐ Dry AMD	RT	LT
☐ BRVO/CRVO	RT	LT
☐ Retinal Tear	RT	LT
☐ Epiretinal Membrane	RT	LT
☐ Diabetic Macular Edema	RT	LT
☐ Non-proliferative Diabetic Retinopathy	RT	LT
☐ Proliferative Diabetic Retinopathy	RT	LT
☐ Vitreous Hemorrhage	RT	LT
☐ Macular Hole	RT	LT
☐ Other: _____	RT	LT

Notes:



REFERRING PHYSICIAN INFORMATION

Referring Physician's Name	Referring Physician's Email		Cell (for emergencies)
Office Address			NPI Number
Contact Name at Office	Title	Phone	Fax
Contact Email	Primary Care Physician		

CynEx Consulting, LLC 7.2019
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Thank you for your referral!
www.SeattleRetinaSpecialist.com