



5402 Summerhill Rd.
Texarkana, Tx. 75503
Phone: (903) 614-3937
Fax: (903) 792-5534

Eye Institute

☐ **CONSULT** (Request for advice / opinion) or ☐ **REFERRAL** (Request for management of care)
(Please only select one request)

REQUESTING PROVIDER INFORMATION

Requesting Provider Name

Requesting Provider Address (street, city, state, zip)

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Requesting Provider Telephone

Requesting Provider Fax Number

NPI #

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APPOINTMENT REQUEST

DIAGNOSIS

☐ **First Available**

☐ **Charles Thornton, MD**

☐ **Roshan George, MD**

☐ **Abel E. Li, MD**

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PATIENT and INSURANCE INFORMATION

Patient Name (First, Middle Initial, Last)

Gender

	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Address

City, State, Zip

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Date of Birth (mm/dd/yyyy)

Social Security #

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Home Telephone

Mobile Telephone

Work Telephone

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Does patient need an interpreter?

If yes, what language?

<input type="checkbox"/> Y <input type="checkbox"/> N	
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Does the patient have medical insurance?

Name of Insurance Company and Plan Number and Group Number

<input type="checkbox"/> Y <input type="checkbox"/> N	
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DOCUMENTATION

Please provide consulting physician with all applicable CLINIC NOTES, HISTORY & PHYSICAL, PREVIOUS PROCEDURES, LABORATORY RESULTS, PATHOLOGY REPORTS, RADIOLOGY REPORTS, AND OPERATIVE REPORTS pertinent to the patients visit. Please fax all documentation to (903) 792-5534.
Thank you in advance for the request and your cooperation.