Duke Eye Center

Neuro-Ophthamology

OFFICE USE ONLY

Appt Date:_____/_____/_____

Time:_____:_____ **am / pm**

Faxed:_____/_____/_____

Duke Eye Center
2351 Erwin Road
Suite 2002
Durham, NC 27705

Office 919-681-9191
Fax 919-684-0547

Consultation Request

Date: _____

Please send all records pertinent to the patient's diagnosis, including any MRI or CT films, as soon as possible via mail or fax.

Patient Name: _____ Duke History #: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Patient E-mail: _____

Accommodations: ☐ Wheel Chair ☐ Fall Risk ☐ Interpreter _____

Referring Physician: _____

Address: _____

Office Phone: _____ Office Fax: _____

Clinical Information

Appointment Type:

☐ Referral ☐ Second Opinion

Reason for Referral: _____

Diagnosis: _____

Please have the patient bring all imaging (reports, CT scans, MRI's).

Insurance Information (attach copy of card if available)

Company: _____ Subscriber ID: _____ Subscriber DOB: _____

Group Number: _____ Subscriber Name: _____

Insurance Contact Number: _____

Referral or Pre-Cert Number: _____

It is very important that you fill this form out completely and legibly.
Incomplete forms may delay the scheduling process.

Thank you for choosing the Duke Eye Center.

DukeHealth