ASSOCIATED RETINAL CONSULTANTS, P.C.

Diseases and Surgery of the Retina and Vitreous

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Viren K. Govindaraju, M.D.
Evgeny Gelman, M.D.

Patient Name: _____ Date: _____

Patient Date of Birth: _____ Patient Phone No.: _____

Referred By: _____

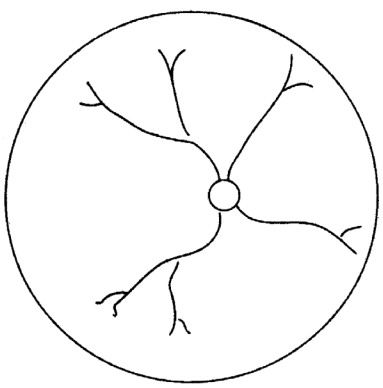
Referring Physician Phone No.: _____ VA: OD _____ OS _____

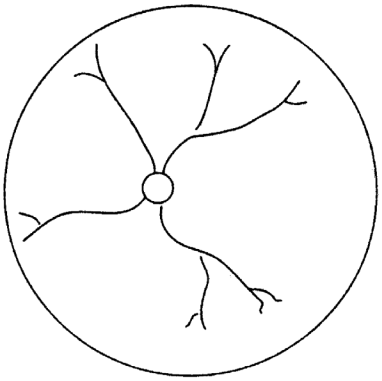
Diagnosis/Reason For Referral: _____

_____

Retinal Consultation

- ☐ Retinal Consultation with Diagnostic Test If Indicated
- ☐ Retinal Consultation Only
- ☐ Fluorescein Angiography OD_____ OS_____ OU_____ Transit? _____
- ☐ Color Photographs OD_____ OS_____ OU_____
- ☐ Indocyanine Green Angiography OD_____ OS_____ OU_____ Transit? _____
  (Royal Oak & Traverse City Offices Only)
- ☐ OCT OD_____ OS_____ OU_____
- ☐ Diagnostic Ultrasound





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