



Center for Glaucoma, Retina & Diabetic Eye Care



CONSULTATION REQUEST

Patient Information

Name: _____ Phone: _____

Address: _____ DOB: _____

City: _____ Zip: _____ SSN#: _____

Email Address: _____

Emergency Contact / Relationship: _____

Emergency Contact Phone#: _____

Employer: _____

Primary Ins: _____ ID/Group#: _____

Secondary Ins: _____ ID/Group#: _____

Does patient have special needs (i.e. wheelchair / mental incapacity): Y N

If yes, please explain: _____

Referring Doctor Information RETURN FAX: _____

Name: _____ Phone: _____

Address: _____

This patient is being referred to **C. JOSEPH BECK, MD - 2700 E. 30th Ave., Hutchinson, KS**

Date of patient's last exam: _____

Referral Diagnosis OD: _____

Referral Diagnosis OS: _____

Completed By: _____

CPE Office Use Only

Date / Time of appt: _____ **CPE Acct#** _____

Please fax completed consultation form, copies of insurance cards, any pertinent records including diagnosis and imaging/testing to (316)712.4987

Updated 06.04.2021