



Minhee Cho, MD
Rahul Mandiga, MD
Benjamin Reiss, MD
Minh Trinh, MD

Please FAX this form to 253-275-9000 or EMAIL it to frontdesk@WAretina.com
Please provide a copy of the patient's most recent office visit, if possible.

Today's Date: _____

Patient Name: _____ DOB: _____

Patient Phone: _____ Insurance: _____

Diagnosis	
<input type="checkbox"/> Dry AMD	<input type="checkbox"/> Retinal Tear
<input type="checkbox"/> Wet AMD	<input type="checkbox"/> Retinal Detachment
<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Flashes/Floaters/PVD
<input type="checkbox"/> BRVO/CRVO	<input type="checkbox"/> Epiretinal Membrane
<input type="checkbox"/> Vitreous Hemorrhage	<input type="checkbox"/> Macular Hole
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Uveitis

Appointment Timeframe			
<input type="checkbox"/> Today/Tomorrow (Please call office)	<input type="checkbox"/> <1 Week	<input type="checkbox"/> <1 Month	<input type="checkbox"/> Next Available

Location		
<input type="checkbox"/> Renton East Pavilion 4009 Talbot Road S #400 Renton, WA 98055	<input type="checkbox"/> Auburn Davis Professional Center 125 3rd St NE #200 Auburn, WA 98002	<input type="checkbox"/> Tacoma Allenmore Building B 1901 S. Union Ave #5004 Tacoma, WA 98405

Pertinent Findings: Va OD: 20/____ OS: 20/____

Referring Doctor: _____

Office Phone: _____ Fax: _____

