WADZINSKI EYE CLINIC
CENTER FOR RETINA EYE CARE

Referring Doctor: _____

Patient Name: _____

Appointment Location: **Sioux City** **Yankton** **Norfolk**
(please circle one)

Appointment Date/Time: _____

Requested Doctor: **Dr. Wadzinski** **Dr. Haeker** **Dr. Shepherd**

Reason for Consult:

- Macular Degeneration
- Macular Pucker
- Flashes / Floaters
- Branch / Central Retinal Vein Occlusion
- Branch / Central Retinal Artery Occlusion
- Retinal Detachment
- Retinal Tear
- Diabetic Retinopathy
- Ocular Trauma
- Uveitis
- Macular Hole
- Other

Comments:

_____

_____

_____

Exam Notes / Records Attached: **Yes** **No**

Michael Wadzinski, MD
Board Certified Ophthalmologist
Fellowship-Trained Vitreoretinal Surgeon

Phone (712)226-3937 **Toll Free (800)572-1249** **Fax (712)224-3973**