



**WADZINSKI EYE CLINIC**  
CENTER FOR RETINA EYE CARE

Referring Doctor: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Policy: \_\_\_\_\_

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

Appointment Date/Time: \_\_\_\_\_

Requested Doctor:      **Dr. Wadzinski**                  **Dr. Korver**                  **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:**

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