ANNAN
RETINA EYE CENTER

Jaafar El-Annan, MD, FACS
Please fax this form to: 346-787-2267
6550 Mapleridge St. Suite # 125 Houston, TX, 77081
P: 346-22ANNAN

REQUESTED APPOINTMENT TIME FRAME

☐ Immediately ☐ Within One Week ☐ WIthin One Month ☐ Other:_____ ☐ When PatientPrefers

PATIENT INFORMATION

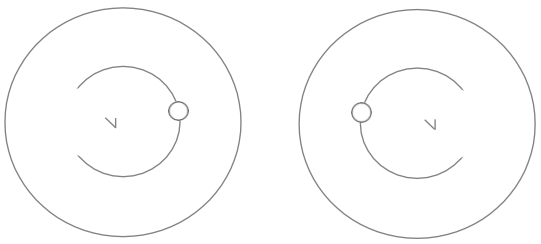
Patient's Name (First, Middle, Last)			Sex ☐ Male ☐ Female
Address			County
City	State	ZIP code	Birth Date (MM/DD/YYYY)
Preferred Phone ☐ cell ☐ home	Alternate Phone ☐ cell ☐ home	Patient's Email Address	
Patient Insurance (please also attach copy of insurance card)		Name, Relationship & DOB of Primary Insured (if not patient)	
Insurance Type ☐ HMO ☐ PPO ☐ Other			

REASON FOR CONSULT

Appointment Type

☐	Wet AMD	RT LT
☐	Dry AMD	RT LT
☐	BRVO/CRVO	RT LT
☐	Retinal Tear	RT LT
☐	Epiretinal Membrane	RT LT
☐	Diabetic Macular Edema	RT LT
☐	Non-proliferative Diabetic Retinopathy	RT LT
☐	Proliferative Diabetic Retinopathy	RT LT
☐	Vitreous Hemorrhage	RT LT
☐	Macular Hole	RT LT
	Other: _____	RT LT

Notes:



REFERRING PHYSICIAN INFORMATION

Referring Physician's Name	Referring Physician's Email		Cell (for emergencies)
Office Address			NPI Number
Contact Name at Office	Title	Phone	Fax
Contact Email	Primary Care Physician		

Thank you for your referral!