



Denton R. Roberts, M.D.

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Daniel J. Gealy, M.D.

Board Certified Ophthalmologists

Fellowship-Trained Vitreoretinal Surgeons

Referring Doctor: _____

Patient Name: _____

Appointment Date/Time: _____

Reason for Consult:

- | | |
|--|--|
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Macular Pucker |
| <input type="checkbox"/> Uveitis | <input type="checkbox"/> Diabetic Retinopathy |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Tapetoretinal Disease |
| <input type="checkbox"/> Ocular Trauma | <input type="checkbox"/> Flashes and Floaters |
| <input type="checkbox"/> Branch/Central Retinal Vein Occlusion | <input type="checkbox"/> Macular Hole |
| <input type="checkbox"/> Branch/Central Retinal Artery Occlusion | <input type="checkbox"/> Retinal Tear |

Map & Address on Back

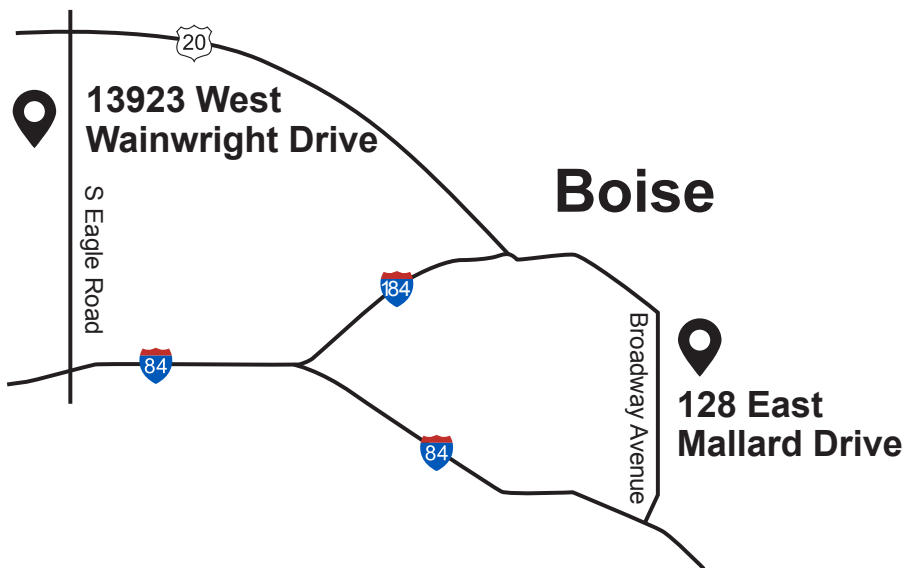
Comments: _____

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