



# Central Pennsylvania Eye Institute

## REFERRAL FORM/CONSULT REQUEST

Please fax completed form to 717-533-5200  
We will call you to confirm the date/time of the consult

### **Referring Doctor Information:**

Name  
Address

Office Number/Contact

### **Patient Information:**

Name  
Date of Birth  
Telephone Number

- Do you want the patient to see: (Please circle one)
  - Dr. Rosenwasser
  - Dr. Pramanik
  - Dr. Strittmatter
  - Next available/No preference
  
- Reason for consult/Question we can answer

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- Where would you like the patient seen? (Please circle one)
  - Hershey Office (preferred if ancillary testing necessary)
  - State College Offices
  - York Office
  - Hospital (Please provide hospital name, room number, nurses station telephone number)\_\_\_\_\_
  
- Comments

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