

**Request for Ophthalmology Consultation with:**



CAMPBELL CUNNINGHAM  
& TAYLOR

**Campbell, Cunningham & Taylor, P.C.**  
**Main Office: 1124 E. Weisgarber Rd.**  
**Knoxville, TN 37909**  
**Phone: 865-584-0905 Fax: 865-934-0287**

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

Patient Birth Date: \_\_\_\_\_

Requested by: \_\_\_\_\_ Phone: \_\_\_\_\_

Requestor Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Referral appointment is scheduled at this Campbell, Cunningham & Taylor office location:  
*[Please circle one]*

Knoxville      Maryville      Farragut      Sevierville      LaFollette

I am sending this patient to your for assistance with his/her care. Please evaluate this patient's problem(s) or condition(s) *[describe]*

\_\_\_\_\_

and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient and will resume general care following your consultation.

Signed \_\_\_\_\_  
*[Referring Doctor]*

***Please send this form via fax to 865-934-0287 in advance of the patient's scheduled referral appointment. Thank you.***