PATIENT REFERRAL FORM

Spectrum Eye Institute

Office Phone: 815-729-3777 FAX 815-725-9373

PATIENT INFORMATION: *(PLEASE PRINT)*

Last: _____ First: _____ MI: _____ Sex: ☐M ☐F

Address: _____ City: _____ State: _____ Zip: _____

Phone: ( ) _____ Alt. Phone: ( ) _____ Type of Insurance: _____

REFERRING PHYSICIAN: *(PLEASE PRINT)*

Name: _____ Practice: _____ Contact: _____

Phone: ( ) _____ Fax: ( ) _____ email: _____

Please fax a copy of the completed form to us @ 815-725-9373

I am referring this patient for the following reason(s). Please check all that apply.

Consultation: ☐Cataract ☐Cornea ☐Glaucoma ☐Pediatric ☐Oculo-Plastics ☐LASIK ☐Retina

Reason for referral: _____

Testing: ☐Visual Field ☐10-2 ☐24-2 ☐30-2 Other _____

☐Optic Nerve Photos ☐Fundus Photos ☐Fluorescein Angiography

OCT: ☐Optic Nerve ☐Macula ☐Topography ☐Pachymetry Other _____

Please Test: ☐OD ☐OS ☐OU *Return*: ☐Test Only ☐Test with Interpretation

ICD-10 Diagnosis Code: _____

Doctor's Signature: _____ Date: _____