SPECIALTY EYE INSTITUTE

AFFILIATE RELATIONS DEPARTMENT

Affiliate Communications Team: PHONE: (866) 399-1790

Affiliate Communications Team: FAX (313) 262-8816

URGENCY

Emergency (<72 hours)

Urgent (4-14 days)

Routine

REFERRING DOCTOR Doctor Name: ______________________ Phone #: ____________

Practice Name/Location: ______________________________ Fax#: ____________

PATIENT Last Name: ______________________ First Name: ____________________

Phone # (H): ______________ Phone # (C): ______________ DOB: ____________

Address: ______________________ City: ____________ State: ______ Zip: ________

Email Address: ________________ Appointment Date: __________ Appointment Time: ______

Primary Care Physician: ________________ Medical Insurance: ____________________

Previous ocular / refractive surgery? ☐ Yes ☐ No If yes, when / type of procedure: ____________________

Amblyopic? ☐ Yes ☐ No Dry Eye History / Therapy? ☐ Yes ☐ No If yes, please indicate drop regimen and date started?

____

Contact Lens Wearer: ☐ Yes ☐ No How many years of contact lens wear? __________

Have contacts been removed? ☐ Yes ☐ No How long has patient been out of contacts? ____________

If yes, what types: ☐ Toric ☐ Multi Focal ☐ Soft ☐ Gas Perm ☐ Other__________

☐ Mono Vision – Near Eye: OD / OS Distance Eye: OD/OS What power to aim for Near:________

SEI Doctor: ____________________ **SEI Location:** ____________________

OCULAR EXAMINATION	**OD**	**OS**
Manifest Refraction and BCVA	____________	____________
Pre Treatment or Max IOP	____________	____________
Current IOP	____________	____________
Anterior Segment	____________	____________
Posterior Segment	____________	____________
K's	____________	____________
Macular Imaging	____________	____________

REQUESTING _____ Consultation Only _____ Consult & Testing _____ Consult & Treat

_____ Ongoing comanagement _____ Transfer of care

DISCUSSIONS WITH PATIENT: Implants/Procedures: Monofocal OD / OS Depth of Focus OD / OS

Toric OD / OS FemtoSecond OD / OS

Diagnosis ____

____

Reason for referral: ____

____

Electronic Signature: