Request for **Diabetic Eye Center**

Illinois Eye Institute - 3241 South Michigan Avenue - Chicago, Illinois 60616-3878
Phone: 312.949.7293 - Fax: 312.949.7693 - www.illinoiseyeinstitute.org

Date of Referral: _____ /_____ /______

Type of Request: ☐ New Diabetic ☐ Return Patient / New Symptoms

Patient Info

Patient Name: ______________________________ **DOB:** _____ /_____ /______

Phone #1: ______________________________ **Phone #2:** ______________________________

Address: ____________________ **City/State:** ____________________ **Zip Code:** ______________

Email: ____

Patient Insurance: ______________________________ Is this HMO? ☐ NO ☐ Yes

ID Number: ______________________________ **Group Number:** ______________________________

PCP ______________________________

Comments

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Referral Info

Reason for Referral (check all that apply):

☐ Annual Diabetic Examination ☐ Follow up Care ☐ Testing Only: OCT ☐ Testing Only: Photo FA

Referral Type:

☐ Urgent (>48hrs) ☐ Number of Weeks: ________ ☐ Number of Months: ______

☐ Next Available ☐ Same Day (please call IEI to schedule)

Referring Doctor: ______________________________ **Office Phone:** ______________________________

NPI # ______________________________ **Office Fax:** ______________________________

Email Address ______________________________ **Contact Person:** ______________________________

☐ Call my patient to make appointment

☐ My patient will call to schedule appointment

☐ Appointment Made _____ /_____ /_____ at ______________________________

Please send this form to
ieireferrals@ico.edu
Fax: 312-949-7693

FOR IEI USE: Patient Contacted:_____ /_____ /_____ Appt. Made _____ /_____ /_____ at __________ Report sent to referring doctor_____ /_____ /_____

Additional Info: ____