ILLINOIS EYE INSTITUTE

# Request for **Diagnostic Testing Services**

**Illinois Eye Institute** - 3241 South Michigan Avenue - Chicago, Illinois 60616-3878
312.225.6200 or 312.949.7255 - www.illinoiseyeinstitute.org

**Date of Referral:** _____ /_____ /_____

**Type of Request:** ☐ Diagnostic Test Only ☐ Diagnostic with Report

## Patient Info

**Patient Name:** _____ **DOB:** _____ /_____ /_____

**Phone #1:** _____ **Phone #2:** _____

**Address:** _____ **City/State:** _____ **Zip Code:** _____

**Email:** _____

**Patient Insurance:** _____ Is this HMO? ☐ NO ☐ Yes

**BCVA:** 20/_____OD 20/_____OS **IOP:** _____OD _____OS

**Refractive Error:** _____ OD _____ OS

## Referral Info

**Diagnostic Testing:**

**Indication(s):** _____ **ICD Code(s):** _____

**Anterior Segment OCT:** _____ Cornea _____ Iris/Angle

**Posterior Segment OCT:** _____ Optic Nerve _____ Retina/Macula _____ Other(specify): _____

**Photos:** ☐ Iris ☐ Cornea ☐ Lid/adnexa ☐ Conjunctiva ☐ Other (specify): _____

**Fluorescein Angiography:** Transit ☐ OD ☐ OS

**Electrodiagnostic Testing:** ☐ ERG ☐ VEP ☐ EOG

**Ultrasonography:** ☐ B-scan ☐ A-scan/IOL Master ☐ UBM ☐ Pachymetry

**Visual Field:** ☐ 24-2 ☐ 10-2 ☐ Kinetic Perimetry ☐ Other (specify): _____

**Other Testing:** ☐ Topography ☐ Endothelial Cell Count ☐ Aberrometry ☐ Tear Lab ☐ Meibography ☐ Global Pachymetry Map

**Referring Doctor:** _____ **Office Phone:** _____

**NPI #** _____ **Office Fax**: _____

☐ Urgent (<48 hours) ☐ Next Available ☐ Same Day (please call IEI to schedule)

☐ 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: 312-949-7347**

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

Additional Info: _____