



General Request for Services

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

Date of Referral: ____ / ____ / ____

Type of Request: Evaluation Only Evaluation & Treatment 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

Reason for Referral (check all that apply):

- Red Eye Dry Eye/Ocular Surface Disease Cornea Disease Uveitis Cataract
- Glaucoma Flashes/Floaters Loss of Vision Diplopia Retina/Vitreous
- Trauma Neuro-ophthalmology Geriatric Eye Exam
- Other Anterior Segment Condition Other Posterior Segment Condition

Other pertinent information, in office treatment, and past treatment: _____

I would like to request a specific doctor for my patient? No Yes (specify): _____

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: _____ |
| <input type="checkbox"/> Urgent (<48 hours) <input type="checkbox"/> Next Available <input type="checkbox"/> Same Day (please call IEI to schedule) | |
| <input type="checkbox"/> Call my patient to make appointment | |
| <input type="checkbox"/> My patient will call to schedule appointment | |
| <input type="checkbox"/> 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: _____