



ILLINOIS EYE INSTITUTE

Request for Pediatric Services

Illinois Eye Institute - 3241 South Michigan Avenue - Chicago, Illinois 60616-3878
312.225.6200 or 312.949.7294 - www.illinoiseyeyeinstitute.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):

- Pediatric Primary Eye Care Exam Amblyopia/Strabismus Evaluation Visual Efficiency Exam
- Sports Vision Exam Developmental/Visual Perception Examination
- Visagraph Testing TOVA Testing
- Pediatric Medical Eye Exam (specify condition): _____
- Pediatric Surgical Consultation (specify condition): _____

Other information: _____

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 Kenetic 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
 Roseanna Rivers
 pedsbv@ico.edu
 Fax: 312-949-7668

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

Additional Info: _____