ILLINOIS EYE INSTITUTE

Request for Services in the
Alfred & Sarah Rosenbloom Center on Vision and Aging

Illinois Eye Institute - 3241 South Michigan Avenue - Chicago, Illinois 60616-3878
312.949.7255 - www.illinoiseyeinstitute.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):

Vision Rehabilitation Services for: ☐Near tasks ☐Distance Tasks ☐Visual Field Enhancement ☐Glare Control
Other Patient Services: ☐Driving Devices ☐Occupational Therapy ☐Social Services ☐Genetic Counseling
Comprehensive Eye Care for: ☐Cataract ☐Glaucoma ☐Flashes/Floaters ☐Loss of Vision ☐Retina/Vitreous ☐Geriatric Eye Exam ☐Other (specify below)
Other pertinent information, in office treatment, or 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): _____

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
Rosenbloom@ico.edu
Fax: 312-949-7638

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