ILLINOIS EYE INSTITUTE

Request for **Surgical 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: ☐ 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):

Cataract: ☐Monofocal IOL ☐Toric IOL ☐Multifocal IOL ☐Accommodating IOL ☐YAG Capsulotomy

Glaucoma: ☐SLT ☐LPI ☐I-Stent ☐Glaucoma Filtration

Retina: ☐AMD ☐Diabetes ☐Macula Disease ☐Retinal hole ☐Detachment ☐Other (specify) ____________

Cornea: ☐Refractive Surgery ☐Keratoconus ☐Other(specify): ____________

Oculoplastics: ☐Chalazion ☐Ptosis ☐Entropion/Ectropion ☐Other(specify): ____________

Pediatrics: ☐Amblyopia/Strabismus ☐Other(specify): ____________

Other pertinent 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 ☐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: ____