Request for **Referral**

Illinois Eye Institute - 3241 South Michigan Avenue - Chicago, Illinois 60616-3878
Phone: 312.225.6200 - www.illinoiseyeinstitute.org

Please send this form to
ieireferrals@ico.edu
Fax: 312-949-7347

Date of Referral: ______ /______ /______

Patient Info

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

Phone #1: ______________________ **Phone #2:** ______________________

Address: ______________ **City/State:** ______________ **Zip Code:** __________

Patient Insurance: ______________________ Is this HMO? ☐ NO ☐ Yes

Referral Info

Referring Patient for: (check all that apply):

☐ Glaucoma	☐ Keratoconus	☐ Pediatrics/Binocular Vision
☐ Retina and Diabetes Eye Service	☐ Corneal Crosslinking	☐ Special Populations Service
☐ Cornea and Contact Lens Service	☐ Cataract	☐ Electrodiagnostic Service
☐ Dry Eye Service	☐ Refractive Surgery Consult	☐ Neuro-Ophthalmology
☐ Myopia Control	☐ Low Vision Rehabilitation	☐ Other (please explain below)

____

Diagnostic Testing

Referring Patient for: (check all that apply):

☐ OCT of anterior chamber angle	☐ Fundus Photos	☐ B-Scan
☐ OCT of ONH	☐ Meibography	☐ Pachymetry
☐ OCT of macula	☐ Topography/ Tomography	☐ Visual Field Testing
☐ OCT with Angioplex	☐ A-Scan/IOL Master	☐ Endothelial Cell Count

Completing this form will allow our consulting doctors to provide correspondence in a timely manner. Please clearly print all fields in bold.

Provider First and Last Name: ______________________________

Practice Phone: ______________________ **Practice Records FAX:** ______________________

Practice Address: ______________________________

City______________ **State:**__________ **Practice 9-Digit Zip Code:** __________

Provider NPI # ______________________________

Provider Email: ______________________________

☐ Call my patient to make appointment ☐ My patient will call to schedule appointment

☐ Appointment Made _____ /_____ /_____ at ______________________

Additional Comments

____