ILLINOIS EYE INSTITUTE

Request for **Referral**

Illinois Eye Institute - 3241 South Michigan Avenue - Chicago, Illinois 60616-3878
Referrals: 312.949.7033 - IEI Phone: 312.225.6200 - www.illinoiseyeinstitute.org

Date of Referral: _____ /_____ /_____

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

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

_____

Diagnostic Testing

Referring Patient for: (check all that apply):

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

_____