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 Indianapolis, IN 46227
 317-782-8844
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DOCTOR REFERRAL FORM

PATIENT INFORMATION

Date _____

Name _____ Home Phone _____ Alt.# _____

Address _____ DOB _____ Age _____

REASON FOR REFERRAL:

- Consultation
 YAG Capsulotomy
 Cataract Evaluation
 Blepharoplasty

Other _____

ORDER FOR SPECIAL TESTING: (check all that apply)

Central Visual Field: OD OS OU Diagnosis: _____

(specify) 30-2 24-2 10-2 (Red) 120 pt screening

OCT Digital Imaging: OD OS OU Diagnosis: _____

Ext./Anterior/Fundus Photos: OD OS OU Diagnosis: _____

Corneal Topography: OD OS OU Diagnosis: _____

Corneal Pachymetry: OD OS OU Diagnosis: _____

Endothelial Cell Count: OD OS OU Diagnosis: _____

Test Results Preference: 1. (check or circle) with / without interpretation

2. (check or circle) with / without evaluation by MD

Best corrected visual acuity with most recent refraction: Date of Refraction _____

OD: _____ x _____ (20/ _____) w/glare (20/ _____) (if available)

OS: _____ x _____ (20/ _____) w/glare (20/ _____) (if available)

Best historical visual acuity: **OD** (20/ _____) **OS** (20/ _____)

Other Eye Disorders or Comments: _____

OTHER INFORMATION (check all that apply)

A-Scan done (Please attach a copy of A-Scan print out if testing was performed in your office.)

Co-Manage (if eligible) **Co-Manage confirmed with patient**

Preference for follow up care **One Week Post-Op** **After Second Eye**

Appointment made at IEC with Dr. _____ **on** _____ **at:** Grnwd Plnfd Indpls

Special Testing Appointment made at IEC on _____

Indiana Eye Clinic to call patient to schedule appointment

Other _____

REFERRING DR _____ OD / MD **PHONE** _____