



Charles O. McCormick, M.D.
 Nicholas R. Rader, M.D.
 William Keeling, Ph.D., M.D.
 David F. Box, M.D.
 Carissa M. Barina, M.D.

GREENWOOD
 30 N. Emerson Avenue
 Greenwood, IN 46143
 317-881-3937
317-887-4011 FAX
 www.indianaeyeclinic.com

PLAINFIELD
 1100 Southfield #1320
 Plainfield, IN 46168
 317-839-7300
317-839-7500 FAX

INDIANAPOLIS
 6423 S. East Street
 Indianapolis, IN 46227
 317-782-8844
317-782-8983 FAX

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: _____

___ External/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** _____