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INDIANAPOLIS
 6423 S. East Street
 Indianapolis, IN 46227
 317-782-8844
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DOCTOR REFERRAL FORM

PATIENT INFORMATION

Date _____

Name _____ 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 w/ Dr. _____ on _____ at: Grnwd Plnfd Indpls other _____
 Special Testing Appointment made at IEC on _____
 Indiana Eye Clinic to call patient to schedule appointment
 Other _____

Follow-up report requested

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

Please submit this form to the Indiana Eye Clinic. Fax numbers are listed above.