

PATIENT REFERRAL FORM

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Paul F. Cacchillo, MD | <input type="checkbox"/> Damon S. Dierker, OD, FAAO | <input type="checkbox"/> Patrick B. Hopen, MD | <input type="checkbox"/> Jan M. Hummer, OD, MD | <input type="checkbox"/> Sarah A. Huseman, OD |
| <input type="checkbox"/> Anthony J. Lombardo, MD, PhD | <input type="checkbox"/> Nathan M. Morrow, OD | <input type="checkbox"/> Michael G. Orr, MD | <input type="checkbox"/> Philip W. Shaffer, OD | <input type="checkbox"/> First Available Doctor |

PATIENT NAME: _____ **DOB:** _____

PATIENT ADDRESS: _____ **PATIENT PHONE:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

MEDICAL INSURANCE: _____ **MEMBER ID:** _____

PREFERRED OFFICE: Indianapolis Anderson Greenfield Greenwood

REFERRING DOCTOR: _____

PRACTICE LOCATION: _____

APPOINTMENT MADE
DATE: _____

PLEASE CALL PATIENT TO SCHEDULE EVALUATION

REASON FOR REFERRAL:

Cataract Evaluation

Suggested refractive target: OD _____ OS _____

Previous LASIK/PRK: Yes Year _____
 No

Co-management of Cataract PO care:

- Yes, Medicare & I am a provider
- Yes, commercial insurance recognizing co-management & I am a provider
- No, I prefer not to co-manage

Patient would likely benefit from:

- Astigmatism treatment
- Presbyopia-correcting IOL
- Glaucoma treatment / MIGS

YAG Laser Capsulotomy

Refractive Lens Exchange Evaluation

Co-management:

- Yes No

Phakic IOL Evaluation

Co-management:

- Yes No

Glaucoma Evaluation

- Assume care
- Opinion on management
- Consider SLT

Retina Evaluation

- Assume care
- Opinion on management
- Macular degeneration
- Diabetic retinopathy

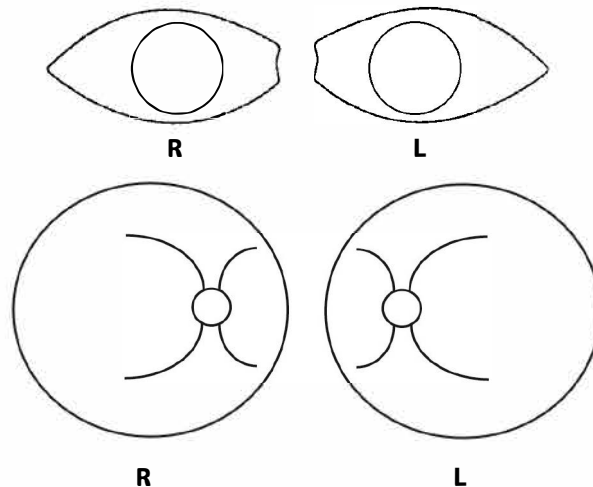
Optic Nerve Evaluation

Cornea Evaluation

Ocular Surface Evaluation

- Assume care
- Opinion on management
- Consider LipiFlow
- Consider Prokera

COMMENTS:





Door-to-Door Transportation Needed on Day of Surgery

Please Fax This Form To Our Referral Concierge: Fax: 317.579.7435 / Ph: 317.841.2028