

- ☐ Paul F. Cacchillo, MD
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- ☐ Damon S. Dierker, OD, FAAO
 ☐ Anthony J. Lombardo, MD, PhD
- ☐ Patrick B. Hopen, MD
 ☐ Michael G. Orr, MD
- ☐ Jan M. Hummer, OD, MD
 ☐ Philip W. Shaffer, OD
- ☐ **First Available Doctor**

PATIENT NAME: _____

DOB: _____

PATIENT PHONE: _____

REFERRAL DATE: _____

MEDICAL INSURANCE: _____

PREFERRED OFFICE:
☐ Indianapolis
 ☐ Anderson
 ☐ Greenfield
 ☐ Greenwood

REFERRED BY: _____

PRACTICE LOCATION: _____

☐ **APPOINTMENT MADE**
DATE: _____

☐ **PLEASE CALL PATIENT
TO SCHEDULE EVALUATION**

☐ **Cataract Evaluation**

Suggested refractive target: OD _____ OS _____

 Previous LASIK/PRK ☐ Yes _____/yr

 Prior LASIK records requested? ☐ Yes ☐ 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
 ☐ Multifocal IOL
 ☐ Monovision
 ☐ ECP/MIGS for glaucoma

Co-management of Refractive PO care:

(e.g. astigmatism treatment/multifocal)

- ☐ Yes
 ☐ No

Prior History? (DM, ▲ IOP, Etc.) (Send Clinic Note)

RX: OD _____ **OS** _____

History of Contacts? ☐ **Monovision?** ☐

☐ **YAG Laser Capsulotomy**

☐ **Refractive Lens Exchange Evaluation**

Co-management:

- ☐ Yes
 ☐ No

☐ **Phakic IOL Evaluation**

Co-management:

- ☐ Yes
 ☐ No

☐ **Glaucoma Evaluation**

- ☐ Assume glaucoma care
 ☐ Opinion on management
 ☐ Consider SLT

☐ **Retina Evaluation**

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

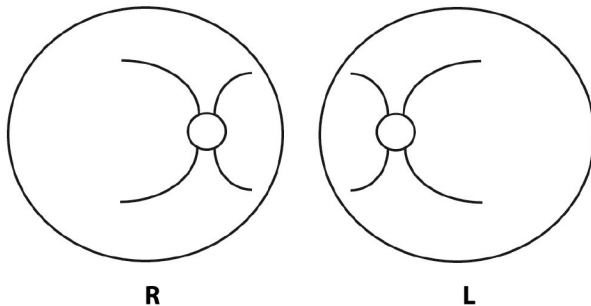
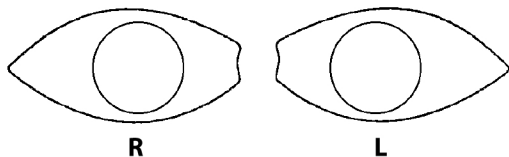
☐ **Diabetic Eye Examination**

☐ **Optic Nerve Evaluation**

☐ **Cornea Evaluation**

☐ **Ocular Surface Evaluation**

- ☐ Consider LipiFlow
 ☐ Consider Prokera



- ☐ **Complimentary 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