TALLEY EYE INSTITUTE

6149 East Columbia Street • Evansville, IN 47715
8341 Express Drive, Suite C • Marion, IL 62959
812.424.2020 • 812.424.3000 fax
www.talleyeyeinstitute.com

New Patient Referral Form

From: _____ Date: _____

Office Location: _____

To:

☐ Anterior Ophthalmology – Any Doctor

☐ Thomas Brummer, MD
☐ Michael Morris, MD
☐ Monica Kalia, OD
☐ Joseph Carr, MD
☐ Dwight Silvera, MD
☐ Nathan Pelsor, OD

☐ Retinal Ophthalmology – Any Doctor

☐ Shivani Reddy, MD
☐ Drew Sommerville, MD
☐ Andrew Strand, DO

****Effective 10/16/2023: Last examination must be attached with the referral form in order for the referral to be reviewed****

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City, St, Zip:** _____

Phone Number: _____

Does the patient reside in a nursing home or a similar facility? ☐ Yes ☐ No

Are you a participating provider for this patient's medical insurance plan? ☐ Yes ☐ No

Do you wish to participate in the post-op co-management for this patient? ☐ Yes ☐ No

Consult Request: **Diagnosis:** _____

☐ **Cataract** ☐ **YAG Cap** ☐ **Cornea** ☐ **Retina** ☐ **LASIK**

☐ **Other**: _____

_____

Request LASIK Info:

☐ Call Patient

☐ Send Literature

☐ **Coordination of Glaucoma Care:**

☐ One Time Consult ☐ Transfer glaucoma management ☐ Comanage

☐ I will follow for routine care only ☐ Other: _____

****Please attach all available visual field and imaging records regarding prior glaucoma treatment to aid in our treatment planning****

Current Glasses Rx:		**Manifest:**		**BCVA**		**Glare:**	
OD:	_____	**OD:**	_____	**OD:**	_____	**OD:**	_____
OS:	_____	**OS:**	_____	**OS:**	_____	**OS:**	_____
Add:	_____						

Does the patient wear contact lenses? ☐ Yes ☐ No ☐ Past ☐ Present

Contact Lens Rx:		**BCVA:**		**Monovision?** ☐
OD:	_____	**OD:**	_____	**OD:** Distance / Near
OS:	_____	**OS:**	_____	**Multifocal?** ☐

Additional Information: _____

_____

For In Office Use Only

Patient contacted by: _____ Appointment Date/Time: _____