Surgical and Medical Eye Care

Secondary Care Referral Form

Patient and Referring Doctor Information

Patient Name: **DOB:**	**Date of Last Exam (92014/92004):**
Patient Address:	**Referring Doctor:**
Patient Phone:	**Referring Office:**
Patient medical history: ☐ Cardiac Patient ☐ Diabetic ☐ Flomax use ☐ LASIK/PRK Date:_____ ☐ Macular Degeneration ☐ Myopic ☐ Hyperopic ☐ Other: _____	**Current Contact Lens History:** ☐ RGP ☐ Soft ☐ Distance only: ☐ OD ☐ OS ☐ OU ☐ Multifocal: ☐ OD ☐ OS ☐ OU ☐ Monovision: Near eye ☐ OD or ☐ OS

☐ Cataract Surgery Evaluation	☐ Evaluation for Surgery	☐ Consultation Requested	☐ Testing Only
☐ OD ☐ OS ☐ OU	☐ OD ☐ OS ☐ OU	☐ OD ☐ OS ☐ OU	☐ OD ☐ OS ☐ OU
Precision Cataract Surgery: ☐ Distance & Near ☐ Distance Only ☐ Near Only ☐ Monovision: Near eye ☐ OD or ☐ OS Post Sx Near Refraction Goal:_____ ☐ *Same Day Requested if Possible* **Surgical Glaucoma Treatment** ☐ Glaucoma ☐ Glaucoma suspect Current Glaucoma Tx:_____ Gonio Last Date:_____ ☐ Attached ☐ Electronic HVF Last Date:_____ ☐ Attached ☐ Electronic OCT Last Date:_____ ☐ Attached ☐ Electronic Pachy Last Date:_____ ☐ Attached ☐ Electronic	☐ Yag Capsulotomy ☐ Selective Laser Trabeculoplasty ☐ Laser Peripheral Iridotomy ☐ Vitreolysis / Floaters ☐ Pterygium ☐ Other: _____	☐ Cornea / Amniotic Membrane ☐ Glaucoma ☐ Macular Degeneration ☐ Diabetic Retinal Evaluation ☐ Oculoplastics ☐ Other: _____	**Interpretation** ☐ *With* ☐ *Without* ☐ OCT ☐ Pachymetry ☐ Photography ☐ Topography ☐ Visual Fields ☐ Other: _____
	Notes:		

Post-Op Appointment

Post-Op Location:	Date & Time:
	1st Eye ☐ **OD** ☐ **OS**
	2nd Eye ☐ **OD** ☐ **OS**

Resumption of Care

The referring doctor is willing to continue treatment if the patient is stable and desires to resume care as follows:

☐ 1 Day Follow-Up	☐ 3 Month Follow-Up	☐ Annual Comprehensive Exam with Refraction	☐ Continuance of Glaucoma Care Follow-Up
☐ 1 Week Follow-Up	☐ 6 Month Follow-Up	☐ Continuance of Diabetic Retinopathy Follow-Up	☐ Other:
☐ 3 Week Follow-Up	☐ 12 Month Follow-Up	☐ Continuance of Macular Degeneration Follow-Up	

Appointment Status

☐ **Cataract & Laser Institute - Fort Wayne, IN**
(800) 874-2164 ● (260) 459-8444 ● Fax: (260) 459-8443

☐ **Cataract & Laser Institute - Fort Wayne - Wayne**
(260) 424-5656 ● Fax: (260) 424-4511

☐ **Cataract & Laser Institute - Greenwood, IN**
(317) 881-3937 ● Fax: (317) 887-4011

☐ **Cataract & Laser Institute - Kokomo, IN**
(800) 882-8239 ● (765) 453-5696 ● Fax: (765) 455-4323

☐ **Cataract & Laser Institute - Plainfield, IN**
(317) 272-2020 ● Fax: (317) 272-6544

☐ **Cataract & Laser Institute - South Bend /Mishawaka, IN**
(574) 271-1114 ● Fax: (574) 271-1644

☐ **Cataract & Laser Institute - Maumee, OH**
(800) 782-9214 ● (419) 865-3866 ● Fax: (419) 865-3451

Referring Doctor's Initials/Date: