The Eye Center
OF SOUTHERN INDIANA
Request for Consultation

☐ Next Available Provider

☐ Provider preference (patient is flexible on timing):

Please fax medical insurance card(s), completed form, and exam records to (812) 333-5039.

MEDICAL INSURANCE INFORMATION

Primary Medical Insurance: Insurance ID #:

PATIENT DEMOGRAPHICS

Today's date:

Patient name: Date of Birth: Phone:

Patient address: City / Zip:

REASON FOR REFERRAL — check all that apply

☐ Cataract — OD ☐ OS ☐

Patient may benefit from:

- ☐ MIGS *include most recent VF*
- ☐ Astigmatism treatment
- ☐ Monovision
- ☐ Presbyopia-correcting IOL
- ☐ Light Adjustable Lens (LAL)

☐ PCO / YAG Capsulotomy — OD ☐ OS ☐

☐ Refractive Surgery / LASIK

☐ Retina — OD ☐ OS ☐

- ☐ Wet AMD
- ☐ Dry AMD
- ☐ Diabetic Retinopathy
- ☐ Other

☐ Glaucoma (Occludable angles? Y / N)

- ☐ SLT Evaluation *include most recent VF*
- ☐ Standalone MIGS Evaluation *include most recent VF*

☐ Lid Lesion — OD ☐ OS ☐

☐ Blepharoplasty

ADDITIONAL NOTES

BEST CORRECTED VISUAL ACUITY

Best corrected VA	OD _____ / _____ with a refraction of _____
	OS _____ / _____ with a refraction of _____
	☐ A change in glasses prescription is not recommended.

☐ Please comanage this case if the patient prefers.	☐ I prefer no comanagement for this case, please.
Name (print):	Signature:

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