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Des Plaines EYE CARE CENTER

Date: _____/_____/_____

CONSULTATION FORM

Patient Information

Name: _____
Last First M.I.

Phone: _____ Date of Birth: _____
Month Day Year

Referring Physician Information

Physician Name: _____
Last First M.I.

Phone: _____ Fax: _____

Address: _____

_____
City State Zip

Insurance Information: _____

For routine exams for patients with HMO insurance, a valid referral authorization from the patient's insurance provider should be faxed or mailed to our office at least two days prior to the appointment.

Reason for Referral (Please check all that apply)

1. OCULAR MANIFESTATIONS OF SYSTEMIC DISEASES:

- ☐ DIABETES MELLITUS
- ☐ HYPERTENSION
- ☐ HYPERLIPIDEMIA
- ☐ MULTIPLE SCLEROSIS
- ☐ SKIN CONDITIONS: ROSACEA/ECZYMA
- ☐ INFLAMMATORY/AUTOIMMUNE CONDITIONS: RA/LUPUS/SJOGRENS/SARCOID/ AS/CROHN'S/GCA/ULCERATIVE COLITIS
- ☐ INFECTIVE CONDITIONS: TOXOPLASMOSIS/FUNGAL/HIV/AIDS/LYME/SYPHILIS
- ☐ CONGENITAL CONDITIONS: ALBANISM/DOWN'S/RETINITIS PIGMENTOSA
- ☐ HAEMATOLOGICAL CONDITIONS: ANEMIA/SICKLE CELL/LEUKAEMIA/ HYPERVISCOCITY

2. EYE CONDITIONS:

- ☐ CATARACTS
- ☐ GLAUCOMA/GLAUCOMA SUSPECT
- ☐ UVEITIS
- ☐ CENTRAL RETINAL VEIN OR ARTERY OCCLUSION
- ☐ MACULAR DEGENERATION
- ☐ AMAUROSIS FUGAX/DIPLOPIA
- ☐ PUPILLARY ABNORMALITIES
- ☐ ABNORMAL EYE MOVEMENTS
- ☐ LID DISEASE/BLEPHARITIS/STYES
- ☐ DRY EYE DISEASE/TEAR FILM DYSFUNCTION

- ☐ **3. CORNEAL DISEASE/TRAUMA/OCULAR SURFACE DISEASE**
- ☐ **4. EYE INFECTION**
- ☐ **5. EYE INJURY/TRAUMA/FOREIGN BODY**
- ☐ **6. REFRACTIVE SURGERY COMANAGEMENT CONSULT**
- ☐ **7. SPECIALTY/THERAPEUTIC CONTACT LENS FITTING**
- ☐ **8. COMPREHENSIVE ANNUAL EYE EXAM WITH VISION EVALUATION**

Patients should bring these items to their appointment:

- Insurance cards and Photo ID
- HMO Authorizations
- Medication Lists
- Name, Address, Phone number of family/physicians

Signature: _____

We thank you very much for the privilege of allowing us to care for your patient. We asked the patient to return back to your office for your excellent care as planned. Thank you for allowing us to participate in the care of your patients