Eye Surgeons of Indiana

Refractive Surgery Referral Form

Please fax or email form and insurance card to 317.579.7435 or referrals@esi-in.com

PATIENT INFORMATION (all patient information required)

Date of Referral _____

Patient Name _____ **DOB** _____

Patient Address _____

City _____ **State** _____ **ZIP** _____

Email _____ **Patient Phone** _____

Referring Doctor _____ **Practice Location** _____

RECOMMENDATION

- ☐ LASIK
- ☐ PRK
- ☐ EVO (high myopia, thinner corneas)
- ☐ RLE (hyperopia/presbyopia)

☐ **Appointment Made**

Date: _____

☐ **Please Call Patient To Schedule Appointment**

REFRACTIVE TARGET

OD ☐ Distance ☐ Near

OS ☐ Distance ☐ Near

CONTACT LENS HISTORY

☐ None ☐ SCL ☐ RGP

☐ Monovision ☐ Distance eye: ☐ OD ☐ OS

☐ Multifocal

Discontinue CL wear 1 week prior to consultation. RGP instructions individualized at consultation.

CURRENT CLINICAL FINDINGS

Significant Ocular/Systemic Conditions: ☐ None ☐ Other _____

Pertinent Slit Lamp/Fundus Findings: ☐ None ☐ Other _____

	OD	**OS**
Contact Lens Rx:	_____	_____
Manifest:	_____	_____
Cycloplegic (1% Cyclogyl):	_____	_____
BCVA:	20/_____	20/_____

Questions? Please call Referral Concierge at 317.841.2028

COMMENTS

SUBMIT