PATIENT CONSULTATION / REFERRAL FORM

ARBOR CENTERS FOR EYECARE

❑ Homewood	2640 W. 183rd Street, Homewood, IL 60430	Tel: (708) 798-6633	Fax: (708) 798-6790
❑ Merrionette Park	11600 S. Kedzie Ave., Merrionette Park, IL 60803	Tel: (708) 388-4400	Fax: (708) 389-8484
❑ Orland Park	9731 W. 165th Street, Orland Park, IL 60467	Tel: (708) 364-0020	Fax: (708) 364-9690
❑ Evergreen Park	2850 W. 95th Street, #401, Evergreen Park IL, 60805	Tel: (708) 499-5500	Fax: (708) 499-4200
❑ Chicago	150 E. Huron, Suite 1000, Chicago, IL 60611	Tel: (312) 944-0195	Fax: (708) 798-6790

PATIENT INFORMATION

Name: _____
Address: _____
Phone: _____
D.O.B. _____

REFERRING DOCTOR INFORMATION

Name: _____
Address: _____
Phone: _____
Fax: _____

REFER TO:

❑ **First available**

Corneal Transplantation, Anterior Segment, & Refractive Surgery
- ❑ David M. Lubeck, M.D.

Eyelid, Tear Duct, Orbital Surgery
- ❑ James F. Kapustiak, M.D., FACS

Medical Retina & Vitreous

Comprehensive Ophthalmology
- ❑ Shivan Tekwani, M.D.

Cataract Surgery
- ❑ David M. Lubeck, M.D.
- ❑ Richard Quinones, M.D.
- ❑ Chris Albanis, M.D.
- ❑ Shivan Tekwani, M.D.
- ❑ Neha Sangal, M.D.
- ❑ Sachin Jain, M.D.

Comprehensive Ophthalmology
- ❑ Chris Albanis, M.D.
- ❑ John Hanlon, M.D.

Glaucoma
- ❑ Richard Quinones, M.D.
- ❑ Marianne Feitl, M.D.
- ❑ Neha Sangal, M.D.
- ❑ Sachin Jain, M.D.
- ❑ First Available

Pediatric Ophthalmology & Adult Strabismus
- ❑ Yuri Kim Kern, M.D.

❑ **Other:**

REFERRAL INFORMATION

- ❑ Consultation with diagnostic testing and initiate treatment. Return to referring doctor for ongoing care.
- ❑ Consultation with diagnostic testing and ongoing treatment, if needed.
- ❑ LASIK Evaluation ❑ Confirmatory Consultation ❑ Diagnostic testing only

If testing is needed, check all that apply:

❑ Visual Field (Humphrey/Matrix/Goldmann)	❑ IOL Master / A-Scan	❑ Retinal OCT
❑ Disc / Fundus Photography	❑ Corneal Topography	❑ Fluorescein Angiography
❑ Optic Nerve OCT / GDx	❑ Endothelial Cell Count	❑ B-Scan
❑ Pachymetry	❑ Confocal Microscopy	❑ Other:

Urgency: ❑ Emergency (to be seen today / tomorrow) ❑ Urgent (to be seen within 1-2 weeks) ❑ Routine

CLINICAL INFORMATION

VA: Right Eye: Left Eye:

IOP: Right Eye: Left Eye:

Clinical History:

APPOINTMENT INFORMATION (Please give a copy of this form to the patient and fax this form to our office.)

- ❑ Appointment scheduled for patient on Date / Time: _____
- ❑ Patient instructed to call the office to make an appointment.
- ❑ Please inform the patient to bring the following items with them to their appointment:
  - ❑ Insurance card(s) and a photo I.D.
  - ❑ Referral (if needed)
  - ❑ Name of the patient's primary care physician
  - ❑ This form
  - ❑ A driver, as the patient's eyes may be dilated.
  - ❑ Phone number of the patient's primary care physician