ARBOR
CENTERS FOR EYECARE

PATIENT CONSULTATION / REFERRAL FORM

	Location	Address	Tel	Fax
❑	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
❑	Hyde Park	1525 E. 53rd Street, Suite 1002, Chicago, IL 60615	Tel: (773) 288-2020	Fax: (773) 324-3704

PATIENT INFORMATION

Name: ______________________________

Address: ______________________________

Phone: ______________________________

D.O.B. ______________________________

E-mail: ______________________________

REFERRING DOCTOR INFORMATION

Name: ______________________________

Address: ______________________________

Phone: ______________________________

Fax: ______________________________

E-mail: ______________________________

REFER TO:

❑ FIRST AVAILABLE

CORNEAL TRANSPLANTATION, ANTERIOR SEGMENT, & REFRACTIVE SURGERY

- ❑ David M. Lubeck, M.D.
- ❑ Fatima Ali, 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.
- ❑ Fatima Ali, M.D.

COMPREHENSIVE OPHTHALMOLOGY

- ❑ Chris Albanis, M.D.

GLAUCOMA

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

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.
  - ❑ This form
  - ❑ Referral (if needed)
  - ❑ A driver, as the patient's eyes may be dilated.
  - ❑ Name of the patient's primary care physician
  - ❑ Phone number of the patient's primary care physician

Please fax completed form to appropriate office number above OR e-mail to peggy.munday@ocularpartners.com