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 ☐ Sarah A. Huseman, OD
☐ Anthony J. Lombardo, MD, PhD
 ☐ Michael G. Orr, MD
 ☐ Philip W. Shaffer, OD
 ☐ **First Available Doctor**

PATIENT NAME: _____

DOB: ____/____/____

PATIENT PHONE: _____

REFERRAL DATE: ____/____/____

MEDICAL INSURANCE: _____

PREFERRED OFFICE: ☐ Indianapolis ☐ Anderson ☐ Greenfield ☐ Greenwood

REFERRED BY: _____

PRACTICE LOCATION: _____

☐ **APPOINTMENT MADE**

____/____/____

☐ **PLEASE CALL PATIENT
TO SCHEDULE EVALUATION**

Suggested refractive target: OD ____ OS ____

Previous LASIK/PRK ☐ Yes ☐ No

If Yes, is refractive history available? ☐ Yes ☐ No

- ☐ Yes, Medicare & I am a provider
☐ Yes, Commercial insurance recognizing co-management & I am a provider
☐ No, I prefer not to co-manage

- ☐ Astigmatism treatment ☐ Multifocal IOL
☐ Monovision ☐ ECP/MIGS for glaucoma

(e.g. astigmatism treatment/multifocal)

- ☐ Yes ☐ No

Co-management:

- ☐ Yes ☐ No

Co-management:

- ☐ Yes ☐ No

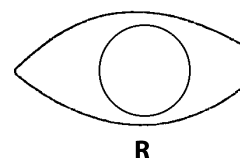
- ☐ Assume glaucoma care
☐ Opinion on management
☐ Consider SLT

- ☐ Assume retina care
☐ Opinion on management
☐ Macular degeneration
☐ Diabetic retinopathy

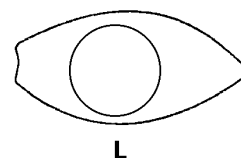
- ☐ Consider LipiFlow
☐ Consider Prokera



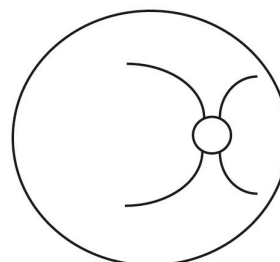
- ☐ Complimentary Door-to-Door
 Transportation Needed on Day of Surgery



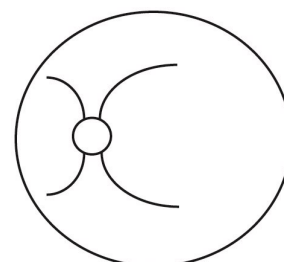
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Please Fax This Form To Our Referral Concierge: Fax: 317.579.7435 / Ph: 317.841.2028