ICON EYECARE

Patient Referral Form
Fax to: 303-757-2679

Is this URGENT? Yes ☐
Phone: 720-930-4254
Date: ____/____/20___

PATIENT INFORMATION

Name:_____ Date of Birth: ____/____/_____

Address:_____

Cell Phone: (_____)_____ - _____ Home/Work Phone: (_____)_____ - _____

Patient's Email:_____

Patient's Medical Insurance:_____ Do you accept Pt.'s Medical Ins.? Y / N

Patient's Medical ID #:_____

REFERRING PROVIDER

Name:_____ Practice: _____

Practice Address:_____

Phone: (_____)_____ - _____ Fax: (_____)_____ - _____

Email: _____

REASON FOR REFERRAL

- ☐ Cataract Evaluation Co-manage? Y / N
- ☐ LASIK/PRK Evaluation Co-manage? Y / N
- ☐ ICL/CLE Evaluation Co-manage? Y / N
- ☐ Corneal Cross-linking
- ☐ Medical Glaucoma Evaluation
- ☐ Surgical Glaucoma Evaluation
- ☐ Medical Diabetic Evaluation
- ☐ Cornea Evaluation
- ☐ Corneal Transplant Evaluation
- ☐ Pterygium
- ☐ Uveitis Evaluation
- ☐ Macular Evaluation
- ☐ Yag Evaluation/SLT Evaluation
- ☐ Dry Eye Evaluation
- ☐ Other: _____

Chief complaint/concern: _____

_____

_____

_____

Please send last exam notes? Y / N

Provider Preference:

- ☐ Eva Kim, M.D.
- ☐ David Litoff, M.D.
- ☐ Greg Fliney, M.D.
- ☐ Menachem Weiss, M.D.
- ☐ Richard Stiverson, M.D.

Patient's Office Preference?

- ☐ Aurora
- ☐ Denver, Colorado Blvd
- ☐ Denver West
- ☐ Lone Tree
- ☐ Parker
- ☐ Westminster

Referring Provider's Signature: _____ Date: _____