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
☐ LASIK/PRK Evaluation
☐ ICL/RLE Evaluation
☐ 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:_____

For Cataract, LASIK, PRK, ICL, RLE Evaluations: Each patient is evaluated by the surgeon and referring optometrist to determine if co-management is appropriate. If so, the patient may choose to receive post-operative care from the referring optometrist, with the surgeon available as needed.

If your patient requests co-management, please indicate whether you would like to co-manage their post-operative care: ☐ Yes ☐ No

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
☐ Cherry Creek
☐ Denver West
☐ Lone Tree
☐ Westminster

Referring Provider's Signature: _____ Date: _____