ILLINOIS eye CENTER

Phone: 309-243-2400
Fax: 309-243-7936

8921 N Wood Sage Rd. Peoria, IL 61615 93 Eastgate Dr. Washington, IL 61571 2709 Broadway Pekin, IL 61554

Patient Consultation Form

Date of Request: _____

General Patient Information

First Name: _____ MI: _____
Last Name: _____
Address: _____
_____
City: _____ State: ___ Zip: _____
Phone: _____
Alt. Phone: _____
Date of Birth: _____
Guarantor Name: _____
Primary Insurance: _____
Primary Insurance ID #: _____

Referring Physician Information

Provider Name: _____
Practice Name: _____
Address: _____
City: _____ State: __ Zip: _____
Phone: _____
Fax: _____
If other than provider, person completing this form:
Name: _____
Phone: _____

Reason for Referral (Chief Complaint & Duration): _____
_____

Type of Visit Requested:

- ☐ Routine Vision to update glasses or contacts
- ☐ Medical Condition Evaluation

Preferred Provider: _____

Timeframe for Consultation:

- ☐ Emergency – must be seen today. Call us @ 243-2400. Fax form after calling.
- ☐ Urgent – within 24 hours
- ☐ Priority – within 1-2 weeks
- ☐ Routine – First Available

Specialty Services Requested:

- ☐ Retina
- ☐ Corneal
- ☐ Diabetic
- ☐ Oculoplastics
- ☐ Testing Only

Please fill out IEC Form -#906

- ☐ Glaucoma:
  Last IOP: OD _____ OS _____
  Date of Last Humphreys VF: _____
- ☐ Cataract

Will the patient be co-managed with your office?

- ☐ No
- ☐ Yes - Please include a Co-Managed Agreement with this referral. Please be sure to have patient sign the agreement. We will not schedule the patient unless the proper forms are completed and received by our office

- ☐ High Risk Medication
  - Name of Medication: _____
  - ☐ Patient is currently taking a high risk medication.
  - ☐ Patient *will be* starting a high risk medication.
  - Diagnosis & ICD-10 Code: _____

In addition to sending the referral and all pertinent patient information, please send the patient's CCD to the following address if your office is participating in Meaningful Use/MACRA: Direct@IllinoisEyeCenterPeoriaIL.CompulinkDirect.com