



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 #: _____

Reason for Referral (Chief Complaint & Duration): _____

Referring Physician Information

Provider Name: _____

Practice Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone: _____

Fax: _____

If other than provider, person completing this form:

Name: _____

Phone: _____

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

Please fill out IEC Form #-906

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

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