



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 #: \_\_\_\_\_

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
- ☐ Neuro - Ophthalmology
- ☐ Testing Only
- ☐ Glaucoma:  
Last IOP: OD \_\_\_\_\_ OS \_\_\_\_\_  
Date of Last Humphreys VF: \_\_\_\_\_
- ☐ Cataract  
Will the patient be co-managed with your office?

Please fill  
out IEC  
Form -#906

- ☐ 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](mailto:Direct@IllinoisEyeCenterPeoriaIL.CompulinkDirect.com)

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