



REFERRING ORDER FOR TESTING ONLY

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

Fax completed forms to Illinois Eye Center (309)243-7936.
Representatives may be reached via phone at (309)243-2400.

PATIENT INFORMATION

Last _____

First _____ MI _____

Address _____

City/St/Zip _____

Phone (home) _____

Phone (cell) _____

Date of Birth ____/____/____

Account Responsible _____

Primary Insurance _____

ID _____ Group _____

(attach front and back copy of all insurance cards)

ORDERING PROVIDER INFORMATION

Physician Name _____

NPI _____

Practice Name _____

Address _____

City/St/Zip _____

Phone _____

Fax _____

Email Address: _____

(some test need to be sent via secure/encrypted email for best view of testing)

Ordering Provider Signature and Date:

_____/____/____

Testing Order:

- Visual Field Goldmann Perimetry 92082
- Visual Field Automated Perimetry 92083
- Image Scan, NFL (OCT) 92133
- Image Scan, Macula (OCT) 92134
- Disc Photos/Fundus Photos 92250
- Ultrasound BSCAN 76512
- Biometry 92136
- Corneal Topography 92025

Eye:

- Right Eye Left Eye Right and Left Eyes

Interpretation:

- with interpretation without interpretation

Diagnosis (ICD10 codes):

- 1 _____ 2 _____
- 3 _____ 4 _____

All tests are scheduled on a first available basis if not. If test results are needed by a specific date, please note below.

THIS BOX TO BE COMPLETED BY ILLINOIS EYE CENTER

Appointment Date: ____/____/____

Appointment Time: _____

Doctor (interpretation only):

Location: Peoria Washington Pekin

IEC Account #: _____

If available to your office, please direct email the patient's CCD to Direct@illinoisEyeCenterPeoriaLL.CompulinkDirect.com.

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