THE EYE GROUP
OF SOUTHERN INDIANA

REFERRAL FORM

Please complete this form AND fax with last two exam notes and last two visual field tests, if available. Incomplete referral forms or a lack of accompanying records could result in a delay in processing this referral.
We will contact your patient directly to schedule an appointment.

☐ **URGENT** ☐ **ROUTINE/NEXT AVAILABLE APPT.**

PHONE:
812-423-3131
FAX:
812-426-7020
EMAIL:
info@eyegroupsi.com

REFERRING DIAGNOSIS:_____

Referring Provider Name:_____

Referring Provider Phone:_____ Fax:_____

Referring to (Circle one if specific provider requested): Dr. Omar Dukar / Dr. Michael Hodges

Is condition chronic or acute/sudden onset?_____

Has condition previously been treated? No/Yes _____

Is there a history of ocular trauma? No/Yes _____

Wears or interested in contact lenses? No/Yes _____

PATIENT INFORMATION

Patient: _____ _____ _____
First M/I Last

Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Address: _____

City / State / Zip: _____

Patient Preferred Phone #: _____

Additional Information/Accommodations Needed: _____

_____

INSURANCE INFORMATION ** Please include front/back copies of all current insurance cards **

Insurance Name: _____

ID #: _____ Group #: _____

Subscriber's Name: _____

Subscriber's Date of Birth: ___ / ___ / ___ Patient Relationship to Subscriber: _____

Secondary Insurance Name:_____

Office Use Only