Price Vision Group

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Patient Referral Form

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☐ Ashlyn Ferguson Lynn, O.D. ☐ Katelyn Lucas, O.D., F.A.A.O ☐ Taylor Hall, O.D. ☐ First available

Patient Name: _____ **DOB:** ____ / ____ / _____

Patient Email: _____ **Patient Phone:** _____

Patient Address: _____

City: _____ **State:** _____ **ZIP:** _____

Medical Insurance: _____ **Insurance ID #:** _____

Referred by: _____

Practice Name: _____ **Practice Phone:** _____

☐ **Appointment Has Been Made on:** ____ / ____ / _____ **at** _____ **am / pm**

☐ **Please Call Patient to Schedule Appointment**

Reason for Referral:

☐ **Cataract Evaluation**
Suggested refractive target: OD _____ OS _____
Previous LASIK/PRK ☐ Yes ☐ No
If Yes, is refractive history available? ☐ Yes ☐ No

Co-management of cataract PO care:
☐ Yes, Medicare & I am a provider
☐ No, I prefer not to co-manage

Patient would likely benefit from:
☐ Astigmatism treatment ☐ Multifocal/EDOF IOL
☐ Monovision

☐ **Refractive Evaluation**
☐ LASIK/PRK
☐ Phakic IOL (Visian ICL)
☐ RLE
Co-manage? ☐ Yes ☐ No

☐ **Cornea Evaluation**

☐ **Glaucoma Evaluation**
☐ Assume glaucoma care
☐ Opinion on management

☐ **YAG Laser Capsulotomy**

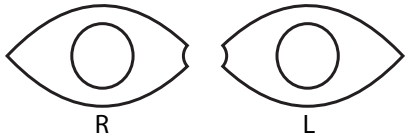
☐ **Dry Eye Evaluation**

☐ **Eye Floater Evaluation**

☐ **Keratoconus Evaluation**

☐ **Other**

Comments:



Please fax this form to: (317) 844-0882 or call: (317) 844-5530 with any questions