independent VISION GROUP

PATIENT REFERRAL

FOR THOMAS HARVEY, MD

Date: _____

REFERRING DOCTOR	
Name:	Clinic:
Office Phone:	Office Fax:

PATIENT INFORMATION			
Name:	Age:	DOB:	Gender: M F
Preferred Phone:	Primary Insurance:		
Referring Diagnosis: OD OS OU	Patient Address:		

Patient is a Contact Lens Wearer: YES NO ☐ If YES, patient advised to remove contacts 2/4 weeks prior to EVAL

Most Recent MRX/Current Glasses RX: _____ OD _____OS

EVALUATION REQUESTED		TESTING REQUESTED
◯ Cataract	◯ Pterygium	◯ Pachymetry
◯ YAG Capsulotomy	◯ Difficult Keratitis/Ulcer	◯ Topography
◯ Laser Vision Correction	◯ Durysta/SLT/YAG PI	◯ OCT
◯ Cornea Transplant	◯ Chalazion/Eye Lesion	◯ Other _____
◯ Crosslinking	◯ Superficial Keratectomy	
◯ LipiFlow	◯ Other	

NOTES	IVG ONLY
	Appt Date:
	Appt Time:
	Clinic Location:

☐ Patient was given PATIENT FOLDER/PRE-EVAL PAPERWORK ☐ Patient DOES NOT have FOLDER/PAPERWORK

Please fax completed referral with exam notes and insurance cards.

Email: referral@inde-vision.com Fax: 715.449.8400 Attn: Thomas Harvey, MD

Questions? Phone/Fax 715.449.8400