SPECIALTY EYE INSTITUTE
By Midwest Vision Partners

AFFILIATE RELATIONS DEPARTMENT (866) 399-1790 Team: FAX (313) 262-8816

URGENCY ☐ Emergency (<72 Hrs) ☐ Urgent (4-14 Days) ☐ Routine

REFERRING DOCTOR: Dr. _____ Phone #: _____

Practice Name/Location: _____ Fax: _____

REQUESTING: ☐ Consultation Only ☐ Consult & Testing ☐ Consult & Treat ☐ Transfer of Care

SEI DOCTOR: _____ SEI LOCATION: _____

Preferred Same Day Surgeon (If applicable): _____ ☐ **Tues** ☐ **Thurs**

PATIENT: Last Name: _____ First Name: _____

Phone #: _____ Email Address: _____DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Appt Date: _____ Appt Time: _____

PCP: _____ Medical Insurance: _____

Previous ocular/refractive surgery? ☐ YES ☐ NO If yes, when/type: _____

Amblyopic? ☐ YES ☐ NO Dry Eye History/Therapy? ☐ YES ☐ NO If yes, please indicate therapy:

Contact Lens Wearer? ☐ YES ☐ NO If yes, how many years of CL wear? _____

Have contacts been removed? ☐ YES ☐ NO How long has patient been out of contacts? _____

If yes, what types: ☐ Toric ☐ Multifocal ☐ Soft ☐ Gas Perm ☐ Other: _____

☐ Monovision – Near eye: ☐ OD/ ☐ OS What power to aim for near? _____

OCULAR EXAMINATION:	**OD**	**OS**
Manifest Refraction & BCVA:	_____	_____
Pre-treatment IOP or TMax:	_____	_____
Current IOP:	_____	_____
Anterior Segment:	_____	_____
Posterior Segment:	_____	_____
K's:	_____	_____
Macular Imaging:	_____	_____

DISCUSSION W PATIENT: Implants/Procedures: Monofocal ☐ OD / OS ☐ Depth of Focus ☐ OD / OS ☐

No Preference ☐ Toric ☐ OD / OS ☐ FemtoSecond ☐ OD / OS ☐ Multifocal ☐ OD / OS ☐

Diagnosis: _____

Reason for referral:_____