



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
 Co-Management Transfer of care

SEI Doctor: _____ **SEI Location:** _____

Same Day Surgery SDS Options: Tuesday Thursday

PATIENT Last Name: _____ First Name: _____

Phone # (H): _____ Phone # (C): _____ DOB: _____

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

Email Address: _____ Appointment Date: _____ Appt Time: _____

Primary Care Physician: _____ Medical Insurance: _____

Previous ocular/refractive surgery? Yes No If yes, when / type of procedure: _____

Amblyopic? Yes No Dry Eye History / Therapy? Yes No If yes, indicate drop regimen & start date: _____

Contact Lens Wearer? Yes No How many years of contact lens wear? _____

Have contacts been removed? Yes No How long has the patient been out of contacts? _____

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

MonoVision – Near Eye: OD / OS Distance Eye: OD / OS What power to aim for Near: _____

OCULAR EXAMINATION Date Of Last Exam: _____ Dilated: Yes No

Manifest Refraction: _____

Current Spectacle Rx: _____

BCVA: _____

Pre Treatment or Max IOP: _____

Current IOP: _____

Anterior Segment: _____

Posterior Segment: _____

Include any Macular Imaging

DISCUSSIONS WITH PATIENT: Implants/Procedures:

Monofocal OD / OS Depth of Focus OD / OS Toric OD / OS FemtoSecond OD / OS

No Preference OD / OS ORA OD / OS

Diagnosis: _____

Reason for referral: _____