BLACK HILLS REGIONAL EYE INSTITUTE

PT. Acct#____________________

Patient Referral Form
Fax 605-341-0278
Phone 605-341-2000

☐ Abraham, Prema, MD Fax 605-719-3321
☐ Spencer, Terrence, MD
☐ Khachikian, Stephen, MD
☐ Jorgensen, Adam, MD
☐ Tarbet, Kristen, MD 1st week of the month
☐ Chappell, Michael, MD 3rd week of the month
☐ Scarborough, Ryan, OD
☐ Bucknall, Karla, OD Low Vision Fax 605-719-3321
☐ Schirber, Scott, OD Laser Vision & Dry Eye Fax 605-719-3330
☐ ____________________

Date ____________________ Please Include Patients Last Exam and Any Additional Testing With This Referral

***Patient Name** ______________________________ **DOB** ____________________

***Patient Phone** H)____________________ C)____________________

***Patient E-Mail** ______________________________ **(For On-line Registration)**

***Medical Insurance** ______________________________

Referred By ______________________________ **Phone** ____________________

Referral Location ______________________________

***Current Refraction**

OD__________ __________ x __________ = 20/ IOP__________

OS__________ __________ x __________ = 20/ IOP__________

Ocular History ______________________________

☐ **Appointment Made**
______/______/______
☐ **Please Call Patient to Schedule Evaluation**
* Please Call Our Office With URGENT Requests

REASON FOR REFERRAL:

*Please Include Patients Last Exam and Any Additional Testing With This Referral

☐ **Cataract Evaluation**
Suggested refractive target OD__________OS__________
Previous LASIK/PRK ☐ Yes ☐ No
If Yes, is refractive history available ☐ Yes ☐ No

☐ **YAG Laser Capsulotomy**

Co-Management of Post-Op Care:
☐ Yes ☐ NO, I prefer not to co-manage
☐ Medicare ☐ Commercial Insurance ☐ ____________________

☐ **Glaucoma Evaluation**
*Testing available and being sent with this referral
☐ Optic Nerve OCT
☐ Visual Field/24-2
☐ Consider SLT Peripheral
☐ Peripheral Iridotomy
☐ Assume Glaucoma Care

☐ **Cornea Evaluation**
☐ **iLASIK or PRK Evaluation**
☐ **Optic Nerve Evaluation**
☐ **Oculoplastics Evaluation**
☐ **Ocular Surface / Dry Eye**
Consider Lipiflow
Consider Prokera

☐ **Retina** ______________________________

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NOTES: ______________________________

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