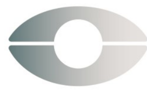
BLACK HILLS REGIONAL EYE INSTITUTE 

2800 Third Street Rapid City, SD

Patient Referral Form

Fax 605-341-0278

Phone 605-341-2000

PT. Acct#________________

- ☐ **Abraham, Prema, MD** Retina | Fax 605-719-3321
- ☐ **Bergman Cory, MD** Comprehensive
- ☐ **Chappell Michael, MD** Oculoplastics
- ☐ **Jorgensen, Adam, MD** Glaucoma & Cataracts
- ☐ **Khachikian, Stephen, MD** Cornea, Cataracts & Refractive
- ☐ **Scarborough,Ryan,OD** Ocular Disease Management & Post-operative Care
- ☐ **Schirber, Scott, OD** Laser Vision & Dry Eye Fax 605-719-3330
- ☐ **Bucknall, Karla, OD** Low Vision Fax 605-719-3321

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:

☐ **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 Cataract PO 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

☐ Assume Glaucoma Care

☐ **Cornea Evaluation**

☐ **iLASIK or PRK Evaluation**

☐ **Oculoplastics Evaluation**

☐ **Ocular Surface / Dry Eye**

☐ **Specialty Contact Lens Fit**

☐ **Retina** ☐ Retinal Tear ☐ Retinal Detachment - Urgent Please Call - 605-341-9190

☐ Other ______________________________

____

Notes: ______________________________

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