SCHOOL OF OPTOMETRY
INDIANA UNIVERSITY
Bloomington

SPECIALTY SERVICES CONSULTATION/REFERRAL FORM

Please fax this form, ALONG WITH ANY PATIENT RECORDS, to the service below.

Please check types of specialty services needed:

	Phone	Fax
☐ **Indianapolis Eye Care Center** (all services)	317.321.1470	317.321.1475
☐ **Atwater Contact Lens**	812.855.2902	812.856.0934
☐ **Atwater Ocular Disease**	812.856.4470	812.855.1683
☐ **Atwater Pediatrics**	812.855.9196	812.856.0934
☐ **Atwater Vision Therapy**	812.855.9196	812.856.0934
☐ **Atwater Low Vision/Vision Rehabilitation**	812.855.9196	812.856.0934
☐ **Atwater Dry Eye**	812.855.2902	812.856.0934

Referred by:

Doctor's Name: ______________________________ Doctor's NPI # _______________ (required)

Office Address: ____

City/State/Zip: ____

Office Phone #: ________________________ Fax #: ______________________

Email: ______________________________________ *I prefer electronic correspondence* ☐

Introducing:

Name: ____ DOB: _____________

Address: ____

City/State/Zip: ____

Phone: _________________________ Contact Phone #: ______________________

I am sending the above patient to the __Indianapolis __Atwater Eye Care Center for the following reasons:

- ☐ Consultation/2nd Opinion only (pt to be returned to original doctor)
- ☐ Transfer of Care (referral)
- ☐ Special Testing with interpretation
- ☐ Special testing without interpretation (technical component only)
- ☐ Treatment/Therapy *(*further Information may be needed upon request*)*

Current or Tentative Diagnosis: ___________________

Other/Comments/Special Requests/Tests requested:

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Would you like us to contact the patient for an appointment? ☐ Yes ☐ No

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Signed ______________________________ Date ___________________