INDIANA UNIVERSITY SCHOOL OF OPTOMETRY
SPECIALTY SERVICES CONSULTATION / REFERRAL FORM

Fax this form, along with any patient records, to the service selected below.

Check the types of specialty services needed:	PHONE	FAX
☐ Indianapolis Eye Care Center (all services) ……	317-278-1470	317-274-1475
☐ 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: _____ Office 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 Clinic for the following reasons:
☐ Consultation / 2nd Opinion only (patient 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:

_____

_____

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

Signed _____ Date _____