## 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)	812-855-2902 812-856-4470 812-855-9196 812-855-9196 812-855-9196 812-855-2902	317-274-1475 812-856-0934 812-855-1683 812-856-0934 812-856-0934 812-856-0934
Doctor's Name:		
Office Address:		
City/State/Zip:		
Office Phone: O	ffice Fax:	
Email:		electronic correspondence
INTRODUCING: Name:Address:		
City/State/Zip:		
Phone: Cor	ntact Phone:	
I am sending the above patient to the Indianapolis Consultation / 2 <sup>nd</sup> Opinion only (patient to be return Transfer of care (referral) Special testing with interpretation Special testing without interpretation (technical con Treatment / therapy (further information may be not sent the sent that the sent the sent that the sent the se	ned to original doctor) mponent only)	nic for the following reasons
Current or Tentative Diagnosis:		-
Other / Comments / Special Requests / Tests requested	d:	
Would you like us to contact the patient for an appoint	ment: Yes N	lo
Signed		Date
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