Specialty Service Referral
Ophthalmology

Sarah Bush Lincoln

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SBL Effingham Ophthalmology
903 Medical Park Drive • Effingham, IL 62401
217-347-2933 • Fax 217-347-2932

REFERRING PROVIDER

Name _____ Phone _____ Fax _____

Reason for Referral (check all that apply) _____ Date _____

- ❑ Cataract Surgery Consultation
- ❑ Glaucoma Consultation
- ❑ Macular Degeneration (with metamorphopsia or sudden vision change)
- ❑ Sudden Vision Loss (OD ❑ OS ❑ OU ❑)
- ❑ Diabetic Eye Disease (with symptoms)
- ❑ Retinal Concern (tear/detachment/vascular/rheumatologic)
- ❑ Recent Ocular Trauma
- ❑ Treatment with High-Risk Medications
- ❑ Vision Changes Associated with Neurological Disease
- ❑ YAG Laser Consultation
- ❑ Macular Degeneration Screening

Optometry Appropriate (may be redirected)

- ❑ Allergic Conjunctivitis
- ❑ Blurred Vision
- ❑ Routine Eye Exam
- ❑ Double Vision
- ❑ Glaucoma Screening
- ❑ Annual Diabetic Eye Exam Screening
- ❑ Glasses/Contacts
- ❑ Routine Pink Eye/Red Eye
- ❑ Dry Eye

PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4# _____

Address _____ City _____ State/Zip _____

Phone _____ County _____

Insurance Carrier Primary _____ Secondary _____

If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # _____

Work Related ❑ Yes ❑ No If yes, Employer _____ Contact _____

Work Comp Carrier _____ Contact _____

INFORMATION NEEDED
Please include all the information below.

- ❑ Provider Notes
- ❑ Procedure Reports
- ❑ Appropriate Laboratory Reports
- ❑ Appropriate Imaging Reports
- ❑ Medication and Allergy Lists

Please indicate specialty needed for referral.

_____

Preferred Provider

_____

Appointment Urgency

- ❑ First available
- ❑ Urgent

REFERRING RESPONSE

❑ Patient Scheduled

Provider _____ Date _____ Time _____

Comment _____

❑ Patient NOT Scheduled

Additional Information Required _____

Other Reason _____