DIAGNOSTIC INSTRUMENT REFERRAL

MEDICAL EYE CENTER

Fax completed form to Comanagement Department: 541-210-8290

REFERRING DOCTOR _____

Address _____

(Please indicate the address to which you would like all results and billing information sent.)

Phone Number _____ Fax _____

REFERRING TO: (Please check one)

❑ Paul Jorizzo, MD ❑ John Welling, MD ❑ Brendan Butler, MD ❑ Ben Taylor, OD
❑ Matt Oliva, MD ❑ Helen Koenigsman, MD ❑ James Davidian, MD ❑ Stacey Hoins, OD
❑ Craig Lemley, MD ❑ Matthew Hauck, MD ❑ Heather French, OD

PATIENT:

Last Name _____ First _____ MI _____ ❑ M ❑ F

Address_____

Phone Number _____ DOB_____

Patient Rx: OD _____ OS _____

Diagnosis Codes_____

Diagnosis_____

Appointment Date_____

PLEASE HAVE PATIENT BRING THEIR BILLING/INSURANCE INFORMATION WITH THEM TO THIS APPOINTMENT.

❑ Patient needs a consult

PLEASE ✔ ALL THAT APPLY	**PLEASE CIRCLE ALL THAT APPLY**	
❑ Automated Visual Field	YES / NO	Ref Doctor to interpret
❑ FDT (Frequency Doubling Technology)	YES / NO	Ref Doctor to interpret
❑ OCT(Heidleberg Optical Coherence Tomography)	YES / NO	Ref Doctor to interpret
❑ Macula	YES / NO	Ref Doctor to interpret
❑ Optic Nerve	YES / NO	Ref Doctor to interpret

The instruments listed below have unlisted service codes which do not have a technical or professional component. Per the advice of Medicare consultants, Medical Eye Center will bill the fee in its entirety. Therefore, all tests below will need to be interpreted by Medical Eye Center.

❑ Wavefront Abberation Mapping
❑ Optomap
❑ Lipiscan / Lipiflow
❑ Pachymeter
❑ Corneal Topography
❑ Corneal Specular Microscopy

NOTES _____

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