MILWAUKEE EYE SURGEONS

# Referral Request Form

Fax To: 414-377-5550

**Patient Information**

Name:_____ Today's Date: _____

Street Address: _____

City, State, ZIP: _____

Phone #:_____ Date of Birth: _____

Insurance Plan & Member Number: _____

_____

**Reason for Referral**:

- ☐ Corneal Cross-Linking
- ☐ Cataract Surgery
- ☐ Corneal Disease
- ☐ LASIK Evaluation
- ☐ Corneal Tattoo
- ☐ Diabetic Eye Exam
- ☐ Corneal Transplant/DSO/DWEK
- ☐ Yag Capsulotomy
- ☐ Glaucoma
- ☐ Yag Vitreolysis

Other Reason for Referral: _____

_____

_____

Note: If you are referring for corneal cross-linking evaluation, please fax the last 6-12 months of topographic/tomographic & refraction information. For all referrals, please include the last 2 clinic notes and any ancillary testing.

**Referring Provider**: _____

Provider Specialty: _____

Practice Name: _____

Office Address: _____

Office Phone #: _____ Office Fax #: _____