VALLEY EYE ASSOCIATES

PRE-OP REFERRAL FORM

Referring Optometrist:

Name: _____

Address: _____

_____

Phone: _____

NPI #: _____

Date of Exam by OD: _____

Date of Appt with VEA: _____

Surgeon:

- ☐ **Michael P. Vrabec, M.D.** NPI #: 1407883838
- ☐ **Douglas F. Salm, M.D.** NPI #: 1033373600
- ☐ **Philip M. Smith, M.D.** NPI #: 1952351876
- ☐ **M. Camille Almond, M.D.** NPI #: 1720098288

Patient Information:

Name: _____

DOB: _____

Address: _____

_____

Phone: _____

Patient Diagnosis:

- ☐ Cataract Type: _____
- ☐ Refractive Error: _____
- ☐ Glaucoma: _____
- ☐ AMD: _____
- ☐ Other: _____

Patient Findings:

BCVA: OD _____ BAT: OD _____ MRef: OD _____

OS _____ OS _____ OS _____

SLE: OD _____ IOP: OD _____ Fundus: OD _____

OS _____ OS _____ OS _____

Contact Lens Wear: (select all) ☐ soft ☐ hard ☐ SV ☐ MF ☐ Monovision

Current Eye Drops: _____

Remarks: _____

_____

Recommended Procedure: **Eye: ☐ OD ☐ OS ☐ OU** (select one)

- ☐ **BLADE CATARACT SURGERY**
- ☐ **HD LASER CATARACT SURGERY**
- ☐ **CUSTOM LENS REPLACEMENT (CLR)**
- ☐ **LASIK OR PRK**
- ☐ **EVO ICL**
- ☐ **SINGLE VISION IOL**
- ☐ **TORIC IOL**
- ☐ **MULTIFOCAL IOL**
- ☐ **LIGHT ADJUSTING IOL**
- ☐ **OTHER:** _____
- ☐ **TARGET REFRACTION**
  - **OD:** Plano or _____
  - **OS:** Plano or _____
- ☐ **IC-8 IOL**

Insurance Information: (to be completed by Optometrist Billing Office)

Patient Insurance: _____

Will Insurance Contract allow for OD co-management?

- ☐ **Yes:** Referring OD will see patient beginning post-op day # (select one): ☐ 1 ☐ 7 ☐ other: _____
- ☐ **No:** Referring OD will see patient after post-op period (select one): ☐ 30 days ☐ 90 days

Please Fax to VEA at (920) 380-9323

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