CIRCLE CITY
NEURO-OPHTHALMOLOGY

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555 E. County Line Road, Suite 102 | Greenwood, IN 46143-1064

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Circle City Neuro-Ophthalmology at Midwest Eye Institute

New Referral Form

****Please fill out ALL of the information below****

Physician Information

Referring Provider: _____

Referring Provider NPI (individual): _____

Practice Address: _____

_____

Phone #: _____

Fax #: _____

- ☐ M.D.
- ☐ D.O.
- ☐ O.D.
- ☐ N.P.
- ☐ P.A.
- ☐ Other _____

Patient Demographics

Patient Name: _____ **DOB:** _____

Patient Address: _____ **SSN:** _____

_____

Home phone #: _____

Cell phone #: _____

Work phone #: _____

E-mail address: _____

Preferred method of contact:

- ☐ Home #
- ☐ Cell #
- ☐ Work #
- ☐ E-mail

Reason(s) for Referral

Diagnosis(es):

- ☐ Vision Loss/VF Defect
- ☐ Papilledema/IIH (PTC)
- ☐ Optic Neuritis
- ☐ Ischemic Optic Neuropathy
- ☐ Optic Atrophy
- ☐ Other Optic Neuropathy
- ☐ Pituitary Adenoma
- ☐ Blepharospasm/ Hemifacial Spasm
- ☐ Thyroid Eye Disease
- ☐ Anisocoria
- ☐ Ptosis
- ☐ Diplopia
- ☐ Nystagmus
- ☐ Other: _____

Onset of Condition: ☐ < 1 wk ☐ 1-2 wks ☐ 3-6 wks ☐ < 3 mos ☐ ≥ 3 mos

Insurance Information

** If a HIP plan, please include the ID # starting with YRK and the State RID number **

Primary Insurance: _____

Policy ID #: _____ **Group #:** _____

Policyholder's Name: _____ **DOB:** _____

Secondary Insurance: _____

Policy ID #: _____ **Group #:** _____

Policyholder's Name: _____ **DOB:** _____

Authorization/Pre-Certification Number: _____

Dates Authorized: _____ to _____

PLEASE FAX THIS FORM ALONG WITH ALL RECORDS (INCLUDING VISUAL FIELDS, OCTs, IMAGING, AND LAB RESULTS) TO (317) 527-4708