BLACK HILLS REGIONAL EYE INSTITUTE

Patient Referral Form

Fax 605-791-3331

Phone 605-341-2000

PT. Acct#_____

2800 Third Street Rapid City, SD Phone 605-341-2000 Fax 605-791-3331 www.bhrei.com

☐ **Abraham, Prema, MD** Retina | Fax 605-719-3321

☐ **Berbos, Zachary, MD** Oculoplastics

☐ **Bergman, Cory, MD** Cataracts & Comprehensive

☐ **Bucknall, Karla, OD** Low Vision Fax 605-719-3321

☐ **daSilva, Michael MD** Cataracts & Refractive

☐ **Jorgensen, Adam, MD** Glaucoma & Cataracts

☐ **Khachikian, Stephen MD** Cornea, Cataracts & Refractive

☐ **Scarborough, Ryan, OD** Ocular Disease Management & Post-operative Care

☐ **Schirber, Scott, OD** Laser Vision & Dry Eye Fax 605-719-3330

Date _____ *Please Include Patients Last Exam and Any Additional Testing with This Referral

***Patient Name** _____ **DOB**_____

***Patient Phone** H)_____ C)_____

***Patient E-Mail** _____ **(For On-line Registration)**

***Medical Insurance** _____

Referred By _____ **Phone**_____

Referral Location _____

***Current Refraction**

OD_____ _____ x _____ = 20/ IOP_____

OS_____ _____ x _____ = 20/ IOP_____

Ocular History_____

_____

☐ **Appointment Made**

_____/_____/_____

☐ **Please Call Patient to Schedule Evaluation**

*** Please Call Our Office With URGENT Requests**

☐ **Cataract Evaluation**

Suggested refractive target OD_____OS_____

Previous LASIK/PRK ☐ Yes ☐ No

If Yes, is refractive history available ☐ Yes ☐ No

☐ **YAG Laser Capsulotomy**

Co-Management of Cataract PO care:

☐ Yes ☐ No, I prefer **not** to co-manage

☐ Medicare ☐ Commercial Insurance ☐ _____

☐ **Glaucoma Evaluation**

*Testing available and being sent with this referral

☐ Optic Nerve OCT

☐ Visual Field 24-2

☐ Consider SLT

☐ Assume Glaucoma Care

☐ **Cornea Evaluation**

☐ **iLASIK or PRK Evaluation**

☐ **Oculoplastics Evaluation**

☐ **Ocular Surface / Dry Eye**

☐ **Specialty Contact Lens Fit**

☐ **Retina** ☐ Retinal Tear ☐ Retinal Detachment - Urgent Please Call - 605-341-9190

☐ Other_____

_____

Notes: _____

_____

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