



PT. Acct# _____

2800 3rd Street Rapid City, SD Phone 605-341-2000 Fax 605-791-3331 www.bhrei.com

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abraham, Prema, MD
Retina Fax 605-719-3321 | <input type="checkbox"/> Berbos, Zachary, MD
Oculoplastics | <input type="checkbox"/> Bergman, Cory, MD
Cataracts & Comprehensive | <input type="checkbox"/> Bucknall, Karla, OD
Low Vision
Fax 605-719-3321 |
| <input type="checkbox"/> Jorgensen, Adam, MD
Glaucoma & Cataracts | <input type="checkbox"/> Khachikian, Stephen MD
Cornea, Cataracts & Refractive | <input type="checkbox"/> Scarborough, Ryan, OD
Ocular Disease Management
& Post-operative Care | <input type="checkbox"/> Schirber, Scott, OD
Laser Vision & Dry Eye
Fax 605-719-3330 |

Date _____ *Please Include Patient's 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

Glaucoma Evaluation
*Testing available and being sent with this referral
 Optic Nerve OCT
 Visual Field 24-2

- Cornea Evaluation**
- Oculoplastics Evaluation**
- Ocular Surface / Dry Eye**
- Specialty Contact Lens Fit**
- LASIK or PRK Evaluation**
- Virtual LASIK Consult**

YAG Laser Capsulotomy

Consider SLT
 Assume Glaucoma Care

Co-Management of Cataract PO care:
 Yes No, I prefer not to co-manage
 Medicare Commercial Insurance _____

Retina Retinal Tear Retinal Detachment - Urgent Please Call - 605-341-9190
 Other _____

Notes: _____

