

Specialty Service Referral Ophthalmology

SBL Pine Eye Center
200 Dettro Dr. • Mattoon, IL 61938
217-348-0221 • Fax 217-345-1380

SBL Effingham Ophthalmology
903 Medical Park Drive • Effingham, IL 62401
217-347-2933 • Fax 217-347-2932



REFERRING PROVIDER

Name _____ Phone _____ Fax _____

Reason for Referral (check all that apply) _____ Date _____

- Cataract Surgery Consultation
- Glaucoma Consultation
- Macular Degeneration (with metamorphopsia or sudden vision change)
- Sudden Vision Loss (OD OS OU)
- Diabetic Eye Disease (with symptoms)
- Retinal Concern (tear/detachment/vascular/rheumatologic)
- Recent Ocular Trauma
- Treatment with High-Risk Medications
- Vision Changes Associated with Neurological Disease
- YAG Laser Consultation
- Macular Degeneration Screening

Optometry Appropriate (may be redirected)

- Allergic Conjunctivitis
- Blurred Vision
- Routine Eye Exam
- Double Vision
- Glaucoma Screening
- Annual Diabetic Eye Exam Screening
- Glasses/Contacts
- Routine Pink Eye/Red Eye
- Dry Eye

PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4# _____

Address _____ City _____ State/Zip _____

Phone _____ County _____

Insurance Carrier Primary _____ Secondary _____

If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # _____

Work Related Yes No If yes, Employer _____ Contact _____

Work Comp Carrier _____ Contact _____

INFORMATION NEEDED

Please include all the information below.

- Provider Notes
- Procedure Reports
- Appropriate Laboratory Reports
- Appropriate Imaging Reports
- Medication and Allergy Lists

Please indicate specialty needed for referral.

Preferred Provider

Appointment Urgency

- First available
- Urgent

REFERRING RESPONSE

- Patient Scheduled

Provider _____ Date _____ Time _____

Comment _____

- Patient NOT Scheduled

Additional Information Required _____

Other Reason _____