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☐ Sohail J. Hasan, MD, PhD
☐ Ramon Lee, MD
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ORLAND PARK
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(708) 364-3240
(708) 364-7252 Fax
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(815) 744-7661 Fax
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☐ Henry L. Feng, MD
☐ John S. Pollack, MD

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(630) 789-5702 Fax
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Oak Park, IL 60304
(708) 660-8450
(708) 660-8454 Fax
☐ Henry L. Feng, MD
☐ Mathew W. MacCumber, MD, PhD
☐ Veena Raiji, MD
☐ Naryan S. Sabherwal, MD

RUSH
1725 West Harrison Street #915
Chicago, IL 60612
(312) 942-2117
(312) 563-2607 Fax
☐ Jack A. Cohen, MD
☐ Sara Fard, MD
☐ Henry L. Feng, MD
☐ Mathew W. MacCumber, MD, PhD
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LOOP
25 East Washington Street #301
Chicago, IL 60602
(312) 726-4949
(312) 726-2368 Fax
☐ Vivek Chaturvedi, MD
☐ Veena Raiji, MD
☐ Naryan S. Sabherwal, MD
☐ E. Anne Shepherd, MD

LINCOLN PARK
2845 North Sheridan Road #900
Chicago, IL 60657
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(773) 871-4781 Fax
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☐ Vivek Chaturvedi, MD
☐ E. Anne Shepherd, MD

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(847) 677-2713 Fax
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☐ Zac B. Ravage, MD

LIBERTYVILLE
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Libertyville, IL 60048
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GLENVIEW
2700 Patriot Boulevard, #130
Glenview, IL 60026
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(847) 773-4565 Fax
☐ Jack A. Cohen, MD
☐ Veena Raiji, MD
☐ Zac B. Ravage, MD

ILLINOIS RETINA ASSOCIATES
THE RETINA CENTER

50 years

REFERRAL FORM

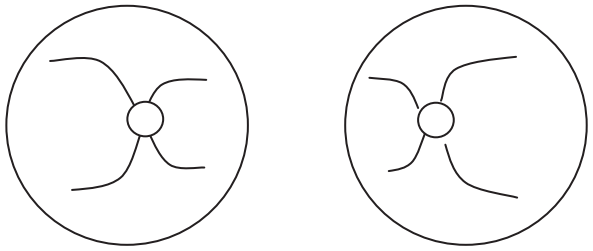
I am sending this patient to you for assistance with his/her care. Please evaluate this patient's problem(s) or condition(s).

DATE	PATIENT NAME	PATIENT D.O.B.	PATIENT PHONE

20-20	Eye	Without Correction	With Correction
	RE		
	LE		

	DILATE BOTH EYES	SPECIAL DILATING INSTRUCTIONS
YES		
NO		

Ocular History: (Diagnostic justification for each eye if tests ordered)	
RE	
LE	

PROCEDURE	PLEASE INDICATE AREAS OF SPECIAL INTEREST ON DRAWING
☐ Retinal Examination with Diagnostic Tests and Treatment, if indicated	
☐ Retinal Examination Only	
☐ Fluorescein Angiogram & Color Photographs Transit RE / LE	
☐ Color Photographs	
☐ OCT	
☐ Ultrasound	
☐ Other	

PRINTED REFERRAL NAME _____

REFERRAL SIGNATURE _____

IRA6-8/25M