ILLINOIS RETINA ASSOCIATES
THE RETINA CENTER

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

VA-OU	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 _____

IRA6-01/26M

HARVEY
71 West 156th Street #400
Harvey, IL 60426
(708) 596-8710
(708) 596-9820 Fax
☐ Joseph M. Civantos, MD
☐ Sara Fard, MD

INDIANA
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(219) 922-9888
(219) 922-9088 Fax
☐ Ramon Lee, MD
☐ Kourous A. Rezaei, MD

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☐ Sohail J. Hasan, MD, PhD
☐ Ramon Lee, MD
☐ Sarah Syeda, MD

ORLAND PARK
16055 108th Avenue, #E
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(815) 744-7661 Fax
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☐ Henry L. Feng, MD
☐ John S. Pollack, MD

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☐ Naryan S. Sabherwal, MD
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LOOP
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(312) 726-2368 Fax
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☐ E. Anne Shepherd, MD

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☐ Zac B. Ravage, MD

LIBERTYVILLE
1800 Hollister Drive #207
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(847) 367-6929 Fax
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