

## Consult/Referral Form

Referral Line 517-337-2725

Referral Fax 517-337-1380

☐ Retinal Specialists:

- ☐ O'Neil Biscette, M.D.  
☐ Ahmed A. El-Sanhouri, M.D.

☐ Corneal Specialist:

- ☐ Matthew M. Yeomans, M.D.

☐ Glaucoma Specialists:

- ☐ Michael J. Bueche, M.D.  
☐ Sonia W. Rana, M.D.  
☐ Michelle You, M.D.

☐ Plastic/Cosmetic Specialist:

- ☐ Craig D. Lewis, M.D.

**Affiliated Offices:**

☐ Alma office - Retinal Specialists:

- ☐ O'Neil Biscette, M.D.  
☐ Ahmed A. El-Sanhouri, M.D.

☐ Cataract/General Ophthalmology:

- ☐ Jeffrey J. Barnes, M.D.  
☐ Michael J. Bueche, M.D.  
☐ Marie T. Burke, M.D.  
☐ James B. Doshi, M.D.  
☐ Amy B. Eston, M.D.  
☐ Stuart P. Landay, M.D.\*  
☐ Kevin J. Liu, D.O.\*  
☐ Deborah MacKersie, M.D.  
☐ John Mackovjak, M.D.\*  
☐ Sonia W. Rana, M.D.  
☐ Matthew M. Yeomans, M.D.\*  
☐ Michelle You, M.D.

*\*Also performs Custom Blade-Free LASIK procedures.*

☐ Optometrist

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Male ☐ Female ☐

Patient DOB: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Vision Insurance: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ M.D., D.O., O.D.

Referring Doctor Phone Number: \_\_\_\_\_

Referring Doctor Fax Number: \_\_\_\_\_

Referring Doctor Email Address: \_\_\_\_\_

Referring Doctor Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Reason for Consult/ER: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Last Refraction: \_\_\_\_\_ OD \_\_\_\_\_20/ OS \_\_\_\_\_20/

Other information:

Office Use:

Appt. Date: \_\_\_\_\_ Appt Time: \_\_\_\_\_ with Doctor: \_\_\_\_\_

**Preferred Method of Communication:**

- ☐ Phone  
☐ Fax  
☐ Mail  
☐ Email

**Cataract Referrals only:**

- ☐ Co-manage care\*  
☐ Return for glasses only  
☐ No co-manage

\*See back of page for more information

## Cataract Co-Management

Thank you for choosing us to take care of your patient's surgical needs. We look forward to working together to manage their ongoing care.

Please follow the guidelines outlined below:

- Complete the consult/Referral form and return to our office
  - For Cataract patients, select the appropriate box:
    - Co-Manage Care
      - ❖ You have discussed this arrangement with the patient and they are requesting that a portion of the post-operative care be provided by their optometrist
      - ❖ Patient has signed letter for request for co-management
      - ❖ Surgery will be billed as co-managed using the 54 and 55 modifiers
    - Return for glasses only
      - ❖ Patient will be retained with surgeon for entirety of post-operative period and returned to optometrist for final glasses Rx only
      - ❖ Surgery will not be billed as co-managed
    - No co-manage
      - ❖ Patient will be retained with surgeon for entirety of post-operative period.
      - ❖ Treated as transfer of care
      - ❖ Surgery will not be billed as co-managed
- Send documentation of best corrected visual acuity (BCVA) and records from most recent visit
- While at L.O. Eye Care, the patient will sign the co-management request form before undergoing cataract surgery. This form will be kept in the patient's chart at our office. A copy will be sent to you as well.
- After cataract surgery and post-operative visits, the patient will be returned to you with a follow up letter.
- At any point during the post-operative period, the surgeon reserves the right to retain the patient for the duration of the post-operative care. This could be due to a complication that arises during or after surgery or because the patient has specifically requested this arrangement.