GREAT LAKES EYE CARE

REFERRAL FORM

Acquired Brain Injury Clinic

Dr. Rachel McKuras, OD · Fax to: **(269) 428-5005**

greateyecare.com

ABI CLINIC 3550 Park Place West, Suite 200 • Mishawaka, IN 46545

1 REFERRING PROVIDER

REFERRING PROVIDER

DATE

NPI (optional)

CLINIC / PRACTICE

CLINIC ADDRESS

OFFICE PHONE

OFFICE FAX

2 PATIENT DEMOGRAPHICS

PATIENT NAME (Last, First)

DATE OF BIRTH

SEX ○ M ○ F ○ X

STREET ADDRESS

CITY

STATE / ZIP

PHONE #1

PHONE #2

EMAIL

PREFERRED CONTACT ○ Phone ○ Text ○ Email

PREFERRED LANGUAGE

3 INSURANCE

Fax a copy of the card(s) if able

PRIMARY

PLAN | MEMBER ID | GROUP NO.

SECONDARY (if any)

PLAN | MEMBER ID | GROUP NO.

4 ACQUIRED BRAIN INJURY DETAILS

Check one in each column

DATE OF INJURY

WORK RELATED? ○ YES ○ NO

TYPE OF INJURY

- ○ Traumatic Brain Injury / Concussion
- ○ Stroke
- ○ Anoxia / Hypoxia
- ○ Infection
- ○ Other:

CAUSE OF INJURY

- ○ Motor Vehicle Accident
- ○ Fall
- ○ Blow to the Head
- ○ Stroke
- ○ Other:

5 PRIMARY DIFFICULTIES & VISUAL SYMPTOMS

Check all that apply

- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye pain / fatigue
- ☐ Headache with eye use
- ☐ Dizziness / nausea with eye movement
- ☐ Loss of balance
- ☐ Loss of side vision
- ☐ Poor depth perception
- ☐ Eyes "not working together"
- ☐ Other:

6 CLINICAL NOTES & RECORDS

REASON FOR REFERRAL / GOALS OF EVALUATION

RELEVANT MEDICAL HISTORY (prior vision therapy, neuro care)

CURRENT MEDICATIONS

RECORDS ENCLOSED

☐ Chart notes ☐ CT / MRI imaging ☐ Neuro / PT / OT notes ☐ Prior eye exam ☐ Medication list ☐ Insurance card

SCHEDULING Our team will contact the patient directly to schedule and will notify the referring office once an appointment is set. Please fax this completed form with relevant medical records to **(269) 428-5005** .