**Referral Form to Mills Eye + Facial Surgery**

**Appointment Requested with:**

☐ Wes Mayes, OD **Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

☐ David M. Mills, MD, FACS

☐ James A. Tammaro, MD

**Patient’s Demographics:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Doctor Information: Primary Care Doctor Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Consultation:**

☐Blind Painful Eye (for Enucleation / Evisceration)

☐Cataract

☐Co-Management Desired?

☐Dermatochalasis with Visual Field Defect

☐Diabetic Dilated Eye Exam

☐Dry Eye / Blepharitis

****LipiFlow Treatment

☐Ectropion

☐Entropion

☐Eyelid Lesion

☐Facial Cosmetic Surgery (Botox, Brow Lift, CO2 Laser, Eyelid Surgery, Face/Neck Lift, Fillers, Liposuction/Fat Transfer)

☐Glaucoma / YAG PI

☐Orbital Disease / Graves’

☐Pediatric OculoPlastics (Dermoid / Orbit, Congenital Ptosis, Tearing)

☐Posterior Capsular Opacification / YAG PC

☐Pterygium

☐Ptosis with Visual Field Defect

☐Routine Eye Exam

☐Refraction (Glasses/Contacts)

☐Refractive Surgery Consult

☐Tearing / Lacrimal

☐Trauma to Eye, Lid, Orbit

☐Trichiasis

☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Instructions / Information – Please READ THIS:**

1. Please bring this form with you.

2. Please bring ALL current insurance cards.

3. It is very likely that your eyes will be dilated —please Bring a Driver.

4. Please bring a current list of medications, current glasses and current contact lenses.

5. Space is limited, so please Bring ONLY 1 driver/guest and leave additional children home. Any children present must NEVER be left unattended by their legal guardian(s).

6. Please be advised that Mills Eye + Facial Surgery collects all applicable co-pays / coinsurance, deductibles, and any balance(s) due at the time of service.

7. If you need a referral/authorization from your Primary Care Physician/Insurance Company, be sure to obtain one prior to visit.

8. Procedures are typically NOT performed at the same time as the evaluation due to insurance restrictions.

9. Some procedures require return appointments for testing to obtain preauthorization due to insurance guidelines.

10. We can NOT (and will not) see minors without the legal guardian’s written consent (even with other adult relatives present).