Ophthalmic *Plastic Surgery, Inc.*

Ronald T. Martin, M.D., FACS
John D. Langford, M.D., FACS
Richard A. Burgett, M.D., FACS
Michael G. Welsh, M.D., FACS
Scott R. Hobson, M.D., FACS
Austin L. Gerber, M.D.

www.opsindy.com

To our Referring Offices,

Here at OPS, we are more than thrilled that you have chosen our Physicians to care for your patients. Your patients could be feeling a bit of apprehension due to the nature of their visit. In order to help with a smooth visit for our mutual patients, we are needing the following information from your office in order to complete the scheduling process in a timely manner.

- ✓ **Patient demographics (name, address and phone numbers).**
- ✓ **Medical insurance information or please send the front and back of each card.**
- ✓ **All office visit notes pertaining to the reason patient is being seen.**
- ✓ **CT scans if applicable.**
- ✓ **Labs if applicable.**
- ✓ **Images if applicable.**
- ✓ **Name of the Physician you would like patient to see.**

We have attached our referral form to complete and return to our office. Please fill the form out entirely if you have not provided the above information. Due to the high demand of referrals in our office, we rely heavily on the referring offices to provide this information for us.

We appreciate you trusting us with your patients!!

Thanks for all you do!

Ophthalmic Plastic Surgery

10300 N Illinois Street, Suite 2020
Carmel, IN 46290
phone (317) 817.1976 or (800) 237.6028
fax (317) 817.1737

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OPS PHYSICIAN REFERRAL FORM

fax to (317) 817.1737 or email to fax@opsindy.com

REFERRING PHYSICIAN INFORMATION

Date: _____ Referred by: _____

To: _____

Address: _____

NPI#: _____

Secure email address: _____

Phone#: _____

Fax#: _____

Has patient previously been seen by OPS? ❑ Yes ❑ No

If yes, by which physician: _____

REASON FOR CONSULTATION

_____

_____

_____

PATIENT INFORMATION

YOU CAN SEND YOUR DEMOGRAPHIC SHEET IF IT COVERS EVERYTHING LISTED.

Patient's Name: _____

DOB: _____ SS#: _____

Address: _____

City: _____ State: _____ ZIP: _____

Patient Phone Number: _____

Work Phone: _____

Cell Phone: _____

Email address: _____

ONLY to be used to communicate with patient regarding appointments

INSURANCE INFORMATION

WE PREFER A COPY OF THE CARD, FRONT AND BACK

Insurance Plan: _____

ID# _____ Effective Date: _____

Is Auth/Pre-Cert Required? ❑ Yes ❑ No If yes, # _____

Secondary Ins: _____

ID# _____

Effective Date: _____

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BEDFORD EVANSVILLE FORT WAYNE GREENWOOD CARMEL/INDIANAPOLIS LAPORTE MUNCIE MUNSTER SOUTH BEND TERRE HAUTE