



**BLACK HILLS REGIONAL EYE INSTITUTE**

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**FAX REFERRAL  
FORM  
FAX # 605-341-9183**

**Referring Physician** \_\_\_\_\_

**NPI#** \_\_\_\_\_

**Referring Physician's Phone #** (        ) \_\_\_\_\_ - \_\_\_\_\_

**Circle One:**

**Dr. Abraham** (Fax: 605-719-3321)

**Dr. Dirks**

**Dr. Hafner**

**Dr. Khachikian**

**Dr. Nixon**

**Dr. Zimmerman**

**Laser Vision Center - Dr. Schirber** (Fax: 605-719-3330)

**Dr. Spencer**

**Low Vision Center-Dr. Bucknall** (Fax: 605-719-3321)

**On Call Doctor**

**Reason for Referral** \_\_\_\_\_

**Patient's Name** \_\_\_\_\_

**Patient's Date of Birth** \_\_\_\_\_

**Patient's Phone # Home:** (        ) \_\_\_\_\_ - \_\_\_\_\_

**Work:** (        ) \_\_\_\_\_ - \_\_\_\_\_

**Has an appointment been made for the patient?**

If yes, date of appointment: \_\_\_\_\_

If no, should we contact the patient to schedule an appointment?      Yes      No

**Medical History** \_\_\_\_\_

**Ocular History** \_\_\_\_\_

**Additional Comments** \_\_\_\_\_

\_\_\_\_\_  
**Signature, Referring Physician**

\_\_\_\_\_  
**Date**