Oregon Eye Specialists, PC

CO-MANAGEMENT REFERRAL FORM

PHYSICIANS

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We Deliver Clarity

Form Int. 127-2 (Rev. 5/2020)

CO-MANAGING DOCTOR: _____

CO-MANAGING LOCATION: _____

PATIENT NAME:

Last _____ First _____ MI _____

Address: _____

Phone: _____ DOB: _____

Please send a copy of the patient's registration information with this form.

Examination Date: _____

Current Glasses: OD _____ 20/_____

OS _____ 20/_____

Significant Medical History: _____

_____

Dominant Eye: ☐ OD ☐ OS IOP: _____ NCT TP AT

Visual Acuity:

	With Correction	Lights On / BAT
OD	20/_____	20/_____
OS	20/_____	20/_____

Manifest Refraction:

OD 20/_____ OS 20/_____

Autokeratometer Reading:

OD _____ OS _____

SLE/FUNDUS, C/D ☐ WNL OU ☐ Abnormalities, note below

OD _____ OS _____

_____ _____

☐ Soft Lens Wearer ☐ RPG Lens Wearer

☐ Advised to leave contacts out _____ before exam

RECOMMENDATIONS

Cataract evaluation w/ Standard	☐ OD	☐ OS
Cataract evaluation w/ Toric IOL	☐ OD	☐ OS
Cataract evaluation w/ Custom IOL	☐ OD	☐ OS
YAG Laser	☐ OD	☐ OS
Other: _____	☐ OD	☐ OS

Appointment made: ☐ Yes, date: _____ ☐ No, please call patient.

Comments: _____

_____

Signature _____ Date _____

>> Please fax completed form to preferred clinic.