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/ ______ OS 20/ ______ OD 20/ ______ OS 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 ☐ RGP 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.