Oregon
Eye Specialists, PC

CO-MANAGEMENT REFERRAL FORM

PHYSICIANS

- ☐ MARTIN J. BALISH, M.D.
- ☐ DANIEL B. BROWN, M.D.
- ☐ KELLY D. CHUNG, M.D.
- ☐ THOMAS I. CRAWFORD II, M.D.
- ☐ DEVIN M. GATTEY, M.D.
- ☐ LORINNA H. LOMBARDI, M.D.
- ☐ NISHA NAGARKATTI-GUDE, M.D., PH.D.
- ☐ JACQUELINE K. NG, M.D.
- ☐ COLEEN PALILEO, M.D.
- ☐ CHRISTEN K. RICHARD, M.D.
- ☐ DAVID SANDERS, M.D.
- ☐ ZOEY E. STOUMBOS, M.D.

☐ ALOHA
GATTEY, NG, NAGARKATTI-GUDE
18345 SW Alexander St, Suite A
P 503.642.2505 | F 503.649.9556

☐ LAKE OSWEGO
GATTEY, NG, NAGARKATTI-GUDE
9 Monroe Parkway, Suite 160
P 503.636.2551 | F 503.636.3055

☐ NEWBERG
PALILEO, SANDERS
Z. STOUMBOS
2318 Portland Road, Suite 300
P 503.538.1341 | F 503.538.1343

☐ PORTLAND – PROVIDENCE
CRAWFORD, RICHARD
Z. STOUMBOS
5050 NE Hoyt St, Suite 445
P 503.231.0166 | F 503.231.2720

☐ PORTLAND – ST. VINCENT
BALISH, BROWN, CHUNG, LOMBARDI
9135 SW Barnes Rd, Suite 961
P 503.292.0848 | F 503.296.0635

☐ TUALATIN - MERIDIAN PARK
PALILEO, SANDERS
19250 SW 65th Ave, Suite 215
P 503.692.3630 | F 503.692.3420

www.oregoneyes.net

We Deliver Clarity

Form Int. 127-2 (Rev. 8/2021)

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 ☐ 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.