



EVERGREEN EYE CENTER

PLEASE FAX TO 206-212-2190

Date _____

Referral Form

Patient _____ Physician Name _____

Patient Phone Number _____ DOB _____ M/F

Reason for Referral

Diagnostic Testing Only _____ ICD-9 code
 Cataracts
 Retina
 Glaucoma
 Other _____

Subjective: _____

Manifest Refraction: OD _____ 20/
 OS _____ 20/

Anterior Segment

OD

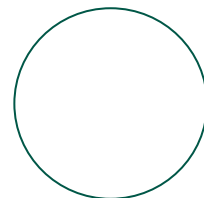
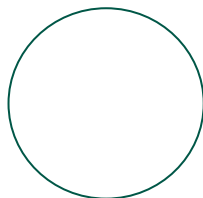
OS

Adnexa	_____	_____
Conj.	_____	_____
Cornea	_____	_____
Lens	_____	_____
A/C	_____	_____
Vit.	_____	_____
IOP	_____	AT/NCT _____

Posterior Segment

OD

OS



Plan _____

When would you like the patient returned? 1-2wks 1mo 3mo

Physician Signature _____

John S. Jarstad, MD
 Board Certified – Eye M.D.
 Cataract Surgery
 Laser Vision Correction

Dean M. Rockey, MD
 Board Certified – Eye M.D.
 Comprehensive Ophthalmology

Robert C. Groth, MD
 1929-2005

Robert A. Tester, MD
 Board Certified – Eye M.D.
 Comprehensive Ophthalmology

Gary W. Chung, MD
 Board Certified – Eye M.D.
 Cornea & External Diseases
 Laser Vision Correction

Linda E. Day, MD
 Board Certified – Eye M.D.
 Vitreoretinal Diseases & Surgery

Bradley A. Frederickson, OD
 Optometric Physician

Richard A. Boudreau, COE
 Certified Ophthalmic Executive
 Administrator