



EVERGREEN EYE CENTER

PLEASE FAX TO 206-212-2193

Date _____

Referral Form

Patient _____ Referring Dr. _____

Patient Phone Number _____ DOB _____ M/F

Reason for Referral

Diagnostic Testing Only
 _____ ICD-9 code

Cataracts
 Glaucoma

Retina
 Other _____

Refractive

Subjective: _____

Manifest Refraction: OD _____ 20/

OS _____ 20/

Anterior Segment

OD

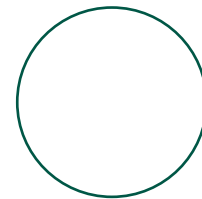
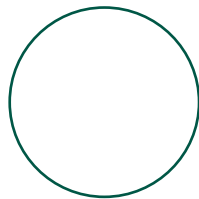
OS

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

_____ OD

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