Leading-edge, patient-centered care.

Eyecare Referral Form

eFax to 855.929.1515

☐ **Emergency** *(pt en route)* ☐ **Urgent** *(24-48 hours)* ☐ **Routine** *(1-2 weeks)*

Patient Name: ______________________ DOB: __________ Patient Phone: ______________ ☐ M ☐ F

Referring Physician: ______________________ Location: ______________ Referral Date: ____________

Manifest Rx

OD: ______________________________ : 20/ IOP: ________

OS: ______________________________ : 20/ IOP: ________

Exam Findings, Referral Dx: ____

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☐ CL Wearer ☐ Eye Meds: ____

Surgical Evaluation: ☐ OD ☐ OS ☐ OU

☐ Cataract ☐ Yag ☐ Refractive ☐ Glaucoma ☐ MIGS ☐ Cross-Linking ☐ Other: ______________

Co-Management of Surgery:

*(Must be contracted with pt's **Medical Insurance** to Co-Manage.)*

- ☐ **Co-Manage:** I will provide post-op care at my office and report back to Evergreen.
- ☐ **No Co-Manage:**
  - ☐ At my request ☐ Per Medical Insurance ☐ Per Patient
- ☐ Retain pt at Evergreen after surgery for monitoring/treatment of ocular disease.
- ☐ Refer pt to me for monitoring/treatment of ocular disease

Medical Evaluation: ☐ OD ☐ OS ☐ OU

☐ Glaucoma ☐ Cornea ☐ Retina ☐ DES ☐ Other: ______________________

Continuity of Care Requested:

- ☐ Retain pt at Evergreen for monitoring of this condition.
- ☐ Refer patient back with recommendations - second opinion only.

Provider Request:

- ☐ Next Available O.D. or M.D.
- ☐ Next Available Surgeon
- ☐ Specific Provider Requested

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Additional Information: ______________________________

Referring Physician Signature: ______________________________