



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 OD: : 20/ IOP:
Rx OS: : 20/ IOP:

Exam Findings, Referral Dx:

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.

Additional Information:

Referring Physician Signature:

Provider Request:

- Next Available
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