

Is this URGENT? Yes Call: 970.256.0400

FAX TO: 970.256.9149

| Referring Provider/Practice: Phone: (| Patient Name: | Date | of Birth: | /_ | / | | ende | r: | |
|---|--|----------------------|------------------|--------------|------------|--------------------|-------------|------------|--|
| Phone: (| Cell Phone Number: (| Home / | Work Phon | e Numb | er: (|) | | | |
| Phone: (| Referring Provider/Practice | | | | | | | | |
| REFERRAL REASON – CHECK ALL THAT APPLY Please include most recent clinic note with relevant testing as well as a copy of patient's insurance card Cataract (DVD given YES/NO) Dry Eye Contact Wearer? Y N Prism Hx? Y N Corneal Crosslinking LASIK/PRK/ICL Dveitis Evaluation Clear Lens Exchange Anterior Segment (iris repair, IOL exchange, other) Glaucoma - Highest IOP on record OD: OS: Concern for angle closure YES/NO/UNKNOWN (for glaucoma evaluations, please include last 5 years of VF's and prior glaucoma allergies if possible) OTHER INFO OR REFERRAL FOR UNLISTED CONDITION: Brief Ocular History: Last Manifest: Date: OD: X 20/ OS: X 20/ Current IOP: OD: OS: Highest Conditions with the patient. For Cataract/ Refractive surgery referrals: Desired vision outcome*Your consultant will thoroughly evaluate/review the candidacy of each option with the patient. Standard (glasses for everything) Distance without glasses (intermediate/near glasses required) Near without glasses (intermediate/distance glasses required) Has patient tolerated monovis | Phone: () - | Fax: (|) | | | | | | |
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| | | | | | | itient toler | ated m | nonovision | |
| ☐ Monovision- Distance Eye = Near Eye = | | _ | . , | | YES | / NO / NO | OT AT | TEMPTED | |
| Target Rx for Near Eye = | | - | | | | | | | |
| Maximum spectacle independence (if patient is good candidate) | | patient is goo | d candidate |) | | | | | |
| ☐ Patient is considering options | · | | • | , | | | | | |
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| DESIRED TEAM APPROACH FOR GLAUCOMA REFERRALS: | DESIRED TEAM APPROACH FOR GLAUCOMA | REFERRALS: | | | | | | | |
| ☐ Referring provider to manage patient when stable | ☐ Referring provider to manage patient | when stable | | | | | | | |
| ☐ Specialist will manage referred condition and patient will continue routine care with referring clinician | | | nt will contin | ue routi | ine care | with refer | ring cl | inician | |
| ☐ Co-Manage care of patient's referred condition | | - | | | | _ | 5 | | |
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| Referring Provider Signature: Date: Date: | | | | | | Date: | | | |