ICON EYECARE

WESTERN SLOPE PATIENT REFERRAL

FAX TO: 970.462.9692

Is this URGENT? Yes ❑
Call: 970.325.2426

Patient Name:_____ **Date of Birth**:_____/_____/_____ **Gender**: _____
Cell Phone Number: (_____) _____-_____ Home / Work Phone Number: (_____) _____- _____
Patient's Preferred Language:_____

Referring Provider/Practice:_____
Phone: (_____) _____-_____ Fax: (_____) _____-_____

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
  Contact Wearer? **Y N** Prism Hx? **Y N**
- ❑ LASIK/PRK/ICL
- ❑ Clear Lens Exchange
- ❑ YAG Capsulotomy
- ❑ 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)*
- ❑ Dry Eye
- ❑ Corneal Crosslinking
- ❑ Laser Floater Therapy (LFT)
- ❑ Anterior Segment
  (iris repair, IOL exchange, other)

OTHER INFO OR REFERRAL FOR UNLISTED CONDITION: _____

Brief Ocular History: _____
Last Manifest: Date:_____ OD:_____ x _____ 20/___ OS: _____ x _____ 20/___
Current IOP: OD:_____ OS:_____

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)
- ❑ Monovision- Distance Eye =_____ Near Eye = _____
  Target Rx for Near Eye = _____
- ❑ Maximum spectacle independence (if patient is good candidate)
- ❑ Patient is considering options

Has patient tolerated monovision:
YES / NO / NOT ATTEMPTED

DESIRED TEAM APPROACH **FOR GLAUCOMA** REFERRALS:

- ❑ Referring provider to manage patient when stable
- ❑ Specialist will manage referred condition and patient will continue routine care with referring clinician
- ❑ Co-Manage care of patient's referred condition

Referring Provider Signature:_____ Date: _____