COMANAGEMENT REFERRAL FORM

MEDICAL EYE CENTER

Fax completed form to our Comanagement Department: 541-210-8290

REFERRING TO: (Please check one)

❑Paul Jorizzo, MD ❑Paul Imperia, MD ❑Matthew Oliva, MD ❑Craig Lemley, MD ❑Matthew Hauck, MD
❑Helen Koenigsman, MD ❑Benjamin Taylor, OD ❑Heather French, OD ❑Stacey Hoins, OD ❑Brendan Butler, MD
❑John Welling, MD ❑James Davidian, MD

COMANAGING DOCTOR _____

REFERRING LOCATION _____**Pt to be seen at**_____

PATIENT: Last Name _____First Name_____ MI____

Address_____

Phone Number_____ Date of Birth _____

PLEASE SEND A COPY OF THE PATIENT'S REGISTRATION INFORMATION WITH THIS FORM

EXAMINATION DATE:_____

Present Spec: OD_____ 20/_____ OS _____20/_____

Significant Medical History: _____

Dominant Eye: ❑ OD ❑ OS IOP: _____ NCT TP AT

Visual Acuity: w/correction - OD 20/_____ OS 20/_____ full room illumination - OD 20/_____ OS 20/_____

Manifest Refraction: OD_____20/_____ OS_____20/_____

Autokeratometer Reading: OD_____ OS_____

SLE/FUNDUS, C/D ❑ WNL OU ❑ Abnormalities, note below

OD _____ OS _____

_____ _____

RECOMMENDATIONS

❑ CATARACT EVALUATION w/ TORIC IOL	❑ OD ❑ OS
❑ CATARACT EVALUATION w/ STANDARD IOL	❑ OD ❑ OS
❑ CATARACT EVALUATION w/ CUSTOM IOL	❑ OD ❑ OS
❑ YAG LASER	❑ OD ❑ OS
❑ CORNEA/EXTERNAL DISEASE CONSULTATION	❑ OD ❑ OS
❑ GLAUCOMA EVALUATION	❑ OD ❑ OS
❑ RETINAL EVALUATION	❑ OD ❑ OS
❑ OCULOPLASTICS EVALUATION	❑ OD ❑ OS
❑ OTHER	❑ OD ❑ OS _____

Appointment Made: ❑ Yes Date:_____ ❑ No Please call patient.

COMMENTS_____

SIGNATURE_____