EYE EXAM REFERRAL

Patient information: Name (First, M.I., Last)____
Birth date (MM/DD/YYYY)_________ Primary language __________________________ E-Mail _______________________
Mailing address ____ City __________ State ____ Zip __________
Primary phone (   )____- _________   Secondary phone (   )____- _________
Current medications ____
Brief Medical History ____

Referring agency contact information and reason for referral:
Office name ____ Phone number (   ) ____-__________
Fax number (   ) ____-_________ E-Mail ____
Date of referral __________
Reason for referral (Check all that Apply):
____ Visual acuity (___Distance ___Near ___Both)
____ Ocular disease (catarct, macular degeneration, etc)
____ Pupillary reflex, red reflex
____ Recent ocular trauma
____ Ocular structure concern (i.e., ptosis (drooping eyelid)
____ Family history of early onset vision problems
____ Long term dose of high risk medication (describe) ____
____ Other (describe) ____

Exam results from Dr. Loren Rodgers:
Date of eye examination: ______________________

Best visual acuity		**Additional Testing (ex. OCT, Visual Field, Fundus Autofluorescence)**
Right	Left	
_____	_____	
Other pertinent findings:		

Check if appropriate:
Treatment recommended
- Medical: ______________
- Glasses
- Contact Lenses
- Other: _______________

Low vision evaluation/assistance recommended
Re-examination advised
- With 6 months
- Within 12 months
- Other: ______________

Other: _________________________________

____

Report attached   Yes   No

Eyes on Main contact information:
ECP Name____ Phone(   )____-__________ Fax (   )____-_____________
Address _______________________________________ City ______________ State ____ Zip ______________________

EYES ON MAIN APPRECIATES YOUR REFERRAL AND WOULD LIKE TO OFFER 10% OFF MATERIALS FOR YOUR PATIENT! (INCLUDES COMPLETE SET OF PRESCRIPTION GLASSES/SUNGLASSES, PLANO SUNGLASSES, OR 1 YEAR SUPPLY OF CONTACTS)