REFERRAL FORM

SISKIYOU EYE CENTER

Fax completed form to Siskiyou Eye Center
Ashland: 541-488-5081 Yreka: 530-842-5839

REFERRING TO: (Please circle one) DATE: _____

☐ **Siskiyou Eye Surgeon** (*next available appointment*) **William Epstein, MD** **Jason Larsen, OD** **Robert Ewing, MD** **David England, OD**

COMANAGING DOCTOR _____

REFERRING LOCATION _____ Pt to be seen at: **Ashland** **Yreka** **Mt Shasta**

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 Hx: _____

Dom Eye: OD / OS IOP: **OD** **OS**

Visual Acuity: w/correction - **OD** 20/_____ **OS** 20/_____

Room illumination / BAT - **OD** 20/_____ **OS** 20/_____

Manifest Refraction: **OD** _____20/____ **OS**_____ 20/_____

Auto K Reading: **OD**_____ **OS**_____

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

OD _____ **OS** _____

_____ _____

RECOMMENDATIONS: **Cataract Surgery** **OD** **OS** Appt Date:_____

STANDARD/ASPHERIC TORIC CRYSTALENS RESTOR NO RECOMMENDATION

☐ MONOVISION CANDIDATE

Yag Laser **OD OS** OTHER:_____

COMMENTS _____

SIGNATURE _____