PREMIER EYE CARE
OF EASTERN IDAHO
MEDICAL · SURGICAL · OPTICAL

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Date _____ From _____

Patient Name _____ Date of Birth _____

Patient Address _____ City _____ State _____ Zip _____

Patient Home Phone _____ Mobile Number _____

Referral Purpose

☐ Cataract ☐ Diabetic Retinopathy ☐ Retinal Evaluation ☐ Glaucoma

Ocular History (include eye meds)

_____

_____

Exam Findings

	OD	OS
Uncorrected Visual Acuity	20/_____	20/_____
Visual Acuity w/ correct SRX	_____ 20/____	_____ 20/____
Manifest Refraction	_____ 20/____	_____ 20/____
Keratometry	____@____/____@____	____@____/____@____
Glare VA (20/50 or worse)	20/_____	20/_____
Amsler Grid Evaluation	Normal _____ Meta _____	Normal _____ Meta _____
IOP	_____ mmHg	_____ mmHg
Pupils	Size _____ / _____	Size _____ / _____

Significant Findings

	OD	OS
EOM	☐ _____	☐ _____
Orbit/Lids/Lacr	☐ _____	☐ _____
Conj/Sclera	☐ _____	☐ _____
Incisions	☐ _____	☐ _____
Cornea	☐ _____	☐ _____
AC/Iris	☐ _____	☐ _____
Lens	☐ _____	☐ _____
IOL/PC	☐ _____	☐ _____
Fundus	☐ _____	☐ _____

Comments/Plans

_____

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