PREMIER EYE CARE OF EASTERN IDAHO

MEDICAL • SURGICAL • OPTICAL

Jason G. Hooton, MD   Kyle G. Thompson, MD   Matthew P. Traynor, MD

2100 Providence Way
Idaho Falls, Idaho 83404
Phone: 208-529-6600 ● Fax: 208-529-6600

Date: ____________________ Referring Doctor: ____

Patient Name: ____ DOB: __________________________

Patient Home Number: ____________________________________ Cell: ____

Patient Address: ____

City: ____ State: ______________________ Zip: _____________________

Reason for Referral:

Cataract   Retina   Cornea   Glaucoma

Ocular History: (Including Meds)

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Exam Findings:	OD	OS
Uncorrected Visual Acuity	20/______________________	20/______________________
Visual Acuity with MRx	20/______________________	20/______________________
Manifest Refraction	_________________________	_________________________
IOP	____________________mmHg	____________________mmHg
Pupils	Size______/________________	Size______/________________

Significant Findings:	OD	OS
EOM	________________________________	________________________________
Orbit/Lids/Lacr	________________________________	________________________________
Conj/Sclera	________________________________	________________________________
Cornea	________________________________	________________________________
AC/Iris	________________________________	________________________________
Lens	________________________________	________________________________
Fundus	________________________________	________________________________

Comments/Plan:

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