



PREMIER EYE CARE

OF EASTERN IDAHO

MEDICAL • SURGICAL • OPTICAL

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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)

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:

