EYE ASSOCIATES NORTHWEST

Please complete this form and fax it to: 206-342-6166

☐ **Emergency** *(pt en route)* ☐ **Urgent** *(24-48 hours)* ☐ **Routine** *(1-2 weeks)*

Patient Name: ______________________ DOB: __________ Patient Phone: ______________ ☐M ☐F

Referring Physician: ______________________ Location: ______________ Referral Date: ____________

Manifest Rx

OD: ________________________________ **: 20/** **IOP:** ________

OS: ________________________________ **: 20/** **IOP:** ________

Exam Findings, Referral Dx: ____

☐CL Wearer ☐Eye Meds: ____

- **Surgical Evaluation:** ☐OD ☐OS ☐OU

  ☐Cataract ☐Yag ☐Glaucoma ☐MIGS ☐Other: ______________

  ☐Retain pt at EANW after surgery for monitoring/treatment of ocular disease.
  ☐Refer pt to me for monitoring/treatment of ocular disease

- **Medical Evaluation:** ☐OD ☐OS ☐OU

  ☐Glaucoma ☐Cornea ☐Retina ☐DES ☐Other: ______________________

- **Continuity of Care:**

  ☐ Retain patient at EANW.
  ☐ Refer patient back with recommendations - second opinion only.

Provider Request:

☐ Next Available O.D. or M.D.
☐ Next Available Surgeon
☐ Specific Provider Requested

Additional Information: ____________________________________

Referring Physician Signature: ______________________________