EYE ASSOCIATES NORTHWEST, PC

Please complete this form and fax 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: _____

- <u>Surgical Evaluation:</u> ☐ 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

  <u>Co-Management of Surgery:</u> *(Must be contracted with pt's **<u>Medical Insurance</u>** to Co-Manage.)*

  ☐ **Co-Manage:** I will provide post-op care at my office and report back to EANW.

  ☐ **No Co-Manage:**

  ☐ At my request ☐ Per Medical Insurance ☐ DES

- <u>Medical Evaluation:</u> ☐ OD ☐ OS ☐ OU

  ☐ Glaucoma ☐ Cornea ☐ Retina ☐ DES ☐ Other: _____

- <u>Continuity of Care:</u>

  ☐ Retain patient at EANW

  ☐ Refer patient back with recommendations - second opinion only

<u>Provider Request:</u>

☐ Next Available O.D. or M.D.

☐ Next Available Surgeon

☐ Specific Provider Requested

Additional Information: _____

Referring Physician Signature: _____