Jason P. Gross, MD
Cataract and Glaucoma Surgery
Diabetic Eye Disease
Comprehensive Ophthalmology

Kent D. Reynolds, O.D.
Doctor of Optometry
Comprehensive Eye Care

EUGENE EYE CLINIC

OPHTHALMOLOGY REFERRAL FORM

Please fax this form to: (541) 683-6672

(Form not required)

Today's Date:		**Referring Physician:**
Patient name:		**Phone:**
		Fax:
Date of Birth:	**Patient's Phone Number:**	**Primary Care Provider:**
Patient's Primary Insurance: ID #: **Patient's Secondary Insurance:** ID #: (Do not need to fill in this portion if providing demographics sheet or copy of card)		☐ **Patient has appointment** _____ ☐ **Please contact patient to schedule appointment** ☐ **Patient will call to schedule appointment**

Patient Needs to Be Seen:

☐ **Today** ☐ **Within 24 Hours** ☐ **Within 1 Week** ☐ **Next Available**

☐ **Cataract Evaluation** ☐ **Glaucoma Evaluation** ☐ **Macular Degeneration Evaluation**
☐ Co-Management preferred if appropriate

☐ **Diabetic Exam** ☐ **Comprehensive Medical Eye Exam**

SIGNS & SYMPTOMS

Pain:	**Right Eye**	**Left Eye**	**Both Eyes**
Redness	**Right Eye**	**Left Eye**	**Both Eyes**
Discharge:	**Right Eye**	**Left Eye**	**Both Eyes**
Epiphora / Tearing:	**Right Eye**	**Left Eye**	**Both Eyes**
Foreign Body Sensation:	**Right Eye**	**Left Eye**	**Both Eyes**
Photophobia:	**Right Eye**	**Left Eye**	**Both Eyes**
Change in visual acuity:	**Right Eye**	**Left Eye**	**Both Eyes**
Flashing Lights:	**Right Eye**	**Left Eye**	**Both Eyes**
Floaters:	**Right Eye**	**Left Eye**	**Both Eyes**

Other (e.g. diplopia, lid swelling): _____

Contact Lens Wearer: **Yes** **No**

Past ophthalmic history (if known): _____

Family ophthalmic history: _____

Eye drops currently used: _____