



**NORTH IDAHO  
EYE INSTITUTE**

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## PHYSICIAN REFERRAL FORM

Requested Surgeon: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Reason for Referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Subjective:

\_\_\_\_\_  
\_\_\_\_\_

	VA cc/sc	NVA cc/sc	Man. Ref		VA cc	IOP
OD:	_____	_____	_____		_____	_____
OS:	_____	_____	_____		_____	_____

Findings:

\_\_\_\_\_  
\_\_\_\_\_

IOL Options Discussed: \_\_\_\_\_

Monofocal: \_\_\_ Distance: \_\_\_ Near: \_\_\_ Monovision: \_\_\_ Multifocal: \_\_\_ Toric: \_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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