



2025 E. 17th Street, Idaho Falls, ID 83404
(208) 524-2025 FAX 529-1924

1157 Call Place, Pocatello, ID 83201
(208) 232-2008 FAX 232-4020

491 First American Circle, Rexburg, ID 83440
(208) 359-1130 FAX 359-2254

Submitting Doctor _____ **Office Location:** _____

Purpose (check one):

- Postop Report
- Referral to IEC

Patient's Name _____ DOB: _____
Patient's Phone: Hm: _____ Wk: _____

- Male
- Female

- Cataract Evaluation
- Corneal Topography
- Diabetic Retinopathy
- Florescein Angiography
- YAG Laser
- Glaucoma Evaluation
- LASIK
- LASIK Enhancement
- Retinal Evaluation
- Strabismus Evaluation

Pertinent Ocular History _____

EXAM FINDINGS: DATE _____

Uncorrected Visual Acuity
Visual Acuity w/current SRX
Manifest Refraction (BVA)
Cycloplegic Refraction
(Cyclogyl 1% x 2, then wait 30' to CR)
Keratometry
Glare VA (20/50 or worse?)
Amsler Grid Eval (circle one)
IOP
Pupils (measured in very dark room)

OD

Distance 20/ _____ Near _____
Distance 20/ _____ Near _____
_____ 20/
_____ 20/
_____ @ _____ / _____ @ _____
20/ _____ (Method) _____
Normal _____ Meta _____
_____ mmHg
Size _____ / _____

OS

Distance 20/ _____ Near _____
Distance 20/ _____ Near _____
_____ 20/
_____ 20/
_____ @ _____ / _____ @ _____
20/ _____ (Method) _____
Normal _____ Meta _____
_____ mmHg
Size _____ / _____

Check box if normal		
<input type="checkbox"/>	EOM	<input type="checkbox"/>
<input type="checkbox"/>	Orbit/Lids/Lacr	<input type="checkbox"/>
<input type="checkbox"/>	Conj/Sclera	<input type="checkbox"/>
<input type="checkbox"/>	Incisions	<input type="checkbox"/>
<input type="checkbox"/>	Cornea	<input type="checkbox"/>
<input type="checkbox"/>	AC/Iris	<input type="checkbox"/>
<input type="checkbox"/>	Lens	<input type="checkbox"/>
<input type="checkbox"/>	IOL/PC	<input type="checkbox"/>
<input type="checkbox"/>	Fundus	<input type="checkbox"/>
Check if patient was dilated		<input type="checkbox"/>

Comments _____
Plans _____
Meds _____

- IEC to make patient's appointment
- Patient already scheduled at IEC

Please mail or fax to Idaho Eye Center
FAX: IF (208) 529-1924 POC (208) 232-4020
REX (208) 359-2254