IDAHO EYE and LASER CENTER

INTEROFFICE FORM

2025 E. 17th St.
Idaho Falls, ID 83404
(208)524-2025 FAX (208)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 (208) 359-2254

706 N. College Rd. Ste C
Twin Falls, ID 83301
(208) 933-2039 FAX (208)933-2035

Submitting Doctor _____ **Office Location:** _____

Purpose (check one):
☐ Postop Report
☐ Referral to IEC

Patient's Name _____DOB:_____ ☐ Male ☐ Female

Patient's Phone: Hm:_____ Wk:_____

☐ Cataract Evaluation ☐ Corneal Topography ☐ Diabetic Retinopathy ☐ Retinal Evaluation ☐ YAG Laser
☐ Glaucoma Evaluation ☐ LASIK/ LASIK Enhancement ☐ Cornea Evaluation ☐ Other:_____

Pertinent Ocular History _____

_____

EXAM FINDINGS: **DATE** _____

	OD	OS
Uncorrected Visual Acuity.	Distance 20/_____Near _____	Distance 20/_____Near _____
Visual Acuity w/current SRX.	Distance 20/_____Near _____	Distance 20/_____Near _____
Manifest Refraction (BVA)	_____20/_____	_____20/_____
Cycloplegic Refraction . . . . . (Cyclogyl 1% x 2,then wait 30' to CR)	_____20/_____	_____20/_____
Keratometry	_____@_____/_____@_____	_____@_____/_____@_____
Glare VA (20/50 or worse?)	20/_____ (*Method*) _____	20/_____ (*Method*) _____
Amsler Grid Eval (circle one)	Normal _____ Meta_____	Normal _____ Meta_____
IOP	_____mmHg	_____mmHg
Pupils (measured in very dark room)	Size _____ /_____	Size _____ /_____

Check box if normal

_____	☐	EOM	☐ _____
_____	☐	Orbit/Lids/Lacr	☐ _____
_____	☐	Conj/Sclera	☐ _____
_____	☐	Incisions	☐ _____
_____	☐	Cornea	☐ _____
_____	☐	AC/Iris	☐ _____
_____	☐	Lens	☐ _____
_____	☐	IOL/PC	☐ _____
_____	☐	Fundus	☐

Check if patient was dilated ☐

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 TWIN (208)933-2035