PATIENT REFERRAL FORM

Date: _____

OREGON TRAIL EYE CENTER, PC

Main Office:
329 W. 40th Street
Scottsbluff, NE 69361
(P) 308-635-3911
(F) 308-635-3130
medicalrecords@otecenter.org

Referred by Dr. _____

Location: _____

Patient's Name: _____ DOB: _____

Patient's Phone: _____ Alt. Number: _____

PLEASE CIRCLE PREFERRED LOCATION:

Scottsbluff, NE | Ainsworth, NE | Valentine, NE | Ogallala, NE | Grant, NE | Douglas, WY

REASON FOR CONSULTATION:

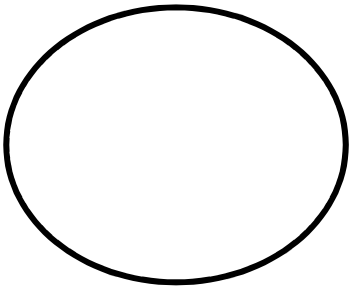
- ☐ Cataract
- ☐ Retina
- ☐ Glaucoma
- ☐ Cornea
- ☐ Occuloplastics
- ☐ Oncology
- ☐ Uveitis
- ☐ Neuro-Oph
- ☐ Dry Eye(s)
- ☐ Other (please specify): _____
- ☐ **TESTING ONLY | NO EXAM**

Circle One: OCT - MAC | OCT - NFL | Pachs | VF | TOPO

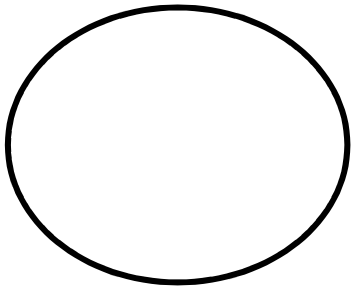
Clinical Details: _____

Refraction: OD _____ 20/ _____ **IOP:** OD _____ **Method:** _____

OS _____ 20/ _____ OS _____



OD



OS

Please note location of any defects on diagrams above.

PLEASE SEND A COPY TO CLINC AS WELL AS A COPY OF THIS FORM WITH THE PATIENT

Fax to: 308-635-3130 OR Email to: medicalrecords@otecenter.org