INSIGHT VISION GROUP

Patient Referral

Date:_____

Doctor's Name: _____ Phone:_____

Contact Email: _____ Fax:_____

Preferred Method of Communication (circle one): Email Fax Letter

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

Please check your doctor preference:

☐Teresa Carlson, OD ☐Starck Johnson, MD ☐Crystal Kasper, OD ☐Ketty Lee, OD ☐Mike Bollenbacher, OD

☐Robert Prouty, OD ☐Richard Stewart, MD ☐Carl Tubbs, MD ☐Thomas Cruse, OD ☐*First Available*

Reason for Referral: Chief Complaint, Ocular History, Visual Acuity, Intraocular Pressures, etc.

_____

_____

Please Indicate:

InSight LASIK: ☐ Refractive Surgery Consult ☐ Cross-Linking Consult ☐ ICL Consult

Insight Vision Group: ☐ One-time Consult ☐ Diagnose and Treat This Problem ☐ Co-manage

☐ Follow patient along with me ☐ Transfer Complete Management ☐ I will follow for Routine Care Only

Additional Services: ☐ Floater Treatment Consult ☐ Serum Tears

For Cataract Surgery Referrals Only: ☐ New technology IOLs, LenSx, and ORA were discussed with my patient and I recommend the following for my patient:

☐ Standard IOL ☐ Toric Package ☐ ReSTOR Package ☐ PanOptix Trifocal Package ☐ Crystalens Package

☐ Trulign Toric-Accommodating Package ☐ Symfony Package ☐ LenSx ☐ ORA ☐ LenSx and ORA

☐ Distance Eye is ☐ OD ☐ OS ☐ Monovision Near Eye: ☐ OD ☐ OS Near Eye Target: _____

☐ Who does post op Cataract care? ☐ Referring OD ☐ Surgeon's office

☐ Secondary Cataract YAG Treatment ☐ OD ☐ OS

If you would like us to do testing only, please circle what you would like done:

☐ With Interpretation Diagnosis Code:_____ ☐ Without Interpretation Diagnosis Code: _____

Visual Fields: Humphrey 24-2 - Humphrey 10-2

Nerve Fiber Analysis: Cirrus (Zeiss) or Avanti (OptoVue) OCT of ONH & macula scan (GCC)

Other: Avanti Angle OCT Scan - Digital fundus photos – Immersion A-scan – IOL master

High Resolution B-scan – Endothelial Cell Count – Pentacam

InSight LASIK

Parker - P: 720.880.6455 F: 720.880.6460 **Boulder - P: 303.402.1000 F: 303.593.2199**

Insight Vision Group

Parker - P: 303.794.1111 F: 303.347.1341 **Lowry - P: 303.671.0000 F: 303.671.2879**

Boulder - P: 303.402.1000 F: 303.593.2199

Fort Collins and Longmont - P: 303.485.1516 F: 303.776.1110

INSIGHT VISION GROUP

Glaucoma Patient Referral

Date:_____

Referring Doctor's Name (Print):_____

Referring Doctor's Address (Print):_____

Phone:_____ Fax:_____

Contact Email: _____

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

Records being sent: Fields -- Nerve Scans -- IOP history -- Medication Hx (include specifics)

(Note: Please mail color data such as OCT scans and other materials that do not fax well. The patient can hand deliver the color data if needed, yet receipt of records before the patient visit will expedite the consultation and treatment plans. For emergency consultations, please call directly and ask our doctor to be interrupted).

Please check your doctor preference:

☐Robert Prouty, OD ☐Richard Stewart, MD ☐Carl Tubbs, MD ☐Teresa Carlson, OD ☐Tom Cruse, OD

☐*First Available*

Reason for Referral (Please be specific: IOP too high? vision loss? OAG suspect? Surgery needed?):

_____

_____

_____

_____

Coordination of Glaucoma care:

☐ One-time consult ☐ Diagnose and treat this problem ☐ Co-manage

☐ Transfer complete management ☐ I will follow for routine care only ☐ Other

For testing only, please indicate desired testing:

Visual Fields:	HFV 24-2 - HVF 10-2 - SWAP
Nerve Fiber Analysis:	Cirrus (Zeiss) or Avanti (OptoVue) OCT of ONH & macula scan (GCC)
Other:	Avanti Angle OCT Scan - Digital fundus photos – Immersion A-scan – IOL master
	High Resolution B-scan – Endothelial Cell Count – Pentacam

Parker P: 303.794.1111 F: 303.347.1341 **Lowry P :303.671.0000 F: 303.671.2879**
Boulder P: 303.402.1000 F: 303.593.2199 **Longmont P: 303.485.1516 F: 303.776.1110**
Fort Collins P: 303.485.1516 F: 303.776.1110

INSIGHT VISION GROUP

Cataract / YAG / SLT Post Op

Referring Doctor: _____ Today's Date: _____/_____/_____

Date of Surgery: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Surgeon:	Starck Johnson Richard Stewart Carl Tubbs

Fax To:	Parker	303.347.1341
	Boulder	303.593.2199
	Lowry	303.671.2879

OD

Date of Exam: ____/_____/_____ Post-op: 1 day 1 week 1 month 3 month other: _____

Type of IOL: _____ Post Op Goal: _____ Meds: _____-_____

UCVA: 20/____ PH: 20/____ IOP: ____mmHg @_____ am / pm MR:_____ _____ x _____20/_____

Cornea: Incision: Normal Open

Edema: None Trace 1+ 2+ 3+ 4+

Striae: None Trace 1+ 2+ 3+ 4+

Anterior Chamber: Cells/Flare: Clear Trace 1+ 2+ 3+ 4+

Pupil: Round Irregular

IOL: Centered Decentered

Posterior Capsule: Clear_____+ Haze _____+ Wrinkles

Macula: Clear CME other: _____

OS

Date of Exam: ____/_____/_____ Post-op: 1 day 1 week 1 month 3 month other: _____

Type of IOL: _____ Post Op Goal: _____ Meds: _____-_____

UCVA: 20/____ PH: 20/____ IOP: ____mmHg @_____ am / pm MR:_____ _____ x _____20/_____

Cornea: Incision: Normal Open

Edema: None Trace 1+ 2+ 3+ 4+

Striae: None Trace 1+ 2+ 3+ 4+

Anterior Chamber: Cells/Flare: Clear Trace 1+ 2+ 3+ 4+

Pupil: Round Irregular

IOL: Centered Decentered

Posterior Capsule: Clear_____+ Haze _____+ Wrinkles

Macula: Clear CME other: _____

Comments:_____

_____

_____.

Dr. Signature: _____

INSIGHT VISION GROUP

LASIK/PRK/ICL Measurements

Referring Doctor:_____

Phone:_____

Please FAX completed form to:
Parker: 720.880.6460
Boulder: 303.593.2199

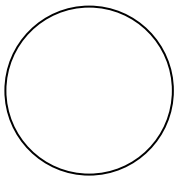
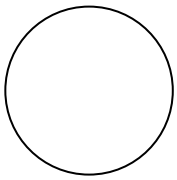
Patient

First Name:	Last Name:	**Allergies:**	Birthdate:

Pre-Surgery Evaluation

	OD	OS		OD	OS	Date
UCVA	20/	20/	Current Rx	20/_____	20/_____	
BCVA	20/	20/	Manifest	20/_____	20/_____	
Zone Quick			Cycloplegic	20/_____	20/_____	
Pachymetry						
Pupil Size (scotopic)			**DVP:**	**WTW:**	Dilation: Cyclogyl 1% 0.5% Trop. 1% Phen. 2.5% @	
Dominant Eye OD OS	APD Yes No		**Pentacam or Other**			
			K's OD X / X	OS X / X		
Angles Open Narrow	Contact Lens Wearer? Yes No		Type:	Date Last Worn:	Stable Yes No	

Ocular Assessment

	OD	OS		OD	OS		OD	OS
Tear Status	Normal Dry	Normal Dry	**Cornea**	Clear Opac Neo Dyst	Clear Opac Neo Dyst	**IOP**	___mmHg @_____	___mmHg @_____
Lids/ Conj	Normal Blepharitis	Normal Blepharitis				**Lens**	Clear Opacity	Clear Opacity
Disc	0. Rd. Tilted Myopic Conus	0. Rd. Tilted Myopic Conus	**Macula**	WNL Myopic Degen Other	WNL Myopic Degen Other	**Peripheral Retina**	WNL Lattice Holes Tear RD	WNL Lattice Holes Tear RD
Pentacam/ Topography	WNL CL Warpage Pathology	WNL CL Warpage Pathology						

Doctor's Signature and Date

Name:	Date	F/U

Surgery Plan

OD	OS	OU	LASIK	PRK	Primary	Enhance	Monovision: Yes No Near Eye OD OS Mono Amt. _____	
					Ziemer	Allegretto		

INSIGHT VISION GROUP

Lasik Post-Op Evaluation

Referring Doctor: _____

Please FAX completed form to:
Parker: 720.880.6460
Boulder: 303.593.2199

Name (First/Last):	Age:	Surgery Date:	Primary / Enhancement

Exam Data

		OD	OS
1 Day 10 Day 2 Mo Other: _____	**Goal:**		**Goal:**
	History	Happy Unsure Unhappy	Happy Unsure Unhappy
	Meds	AT's ____ x a day	AT's _____ x a day
	Acuity	UCVA 20/	UCVA 20/ UCVA OU 20/
	Refraction	20/	20/
	Flap	Good SPK Debris Straie DLK EI Other: _____	Good SPK Debris Straie DLK EI Other: _____
	Assessment	Good Unsure Enhance	Good Unsure Enhance
	Plan	RTC InS CoMg	RTC InS CoMg

Notes:

Today's Date _____ Doctor's Signature

Exam Data

		OD	OS
1 Day 10 Day 2 Mo Other: _____	**History**	Happy Unsure Unhappy	Happy Unsure Unhappy
	Meds	AT's ____ x a day	AT's _____ x a day
	Acuity	UCVA 20/	UCVA 20/ UCVA OU 20/
	Refraction	20/	20/
	Flap	Good SPK Debris Straie DLK EI Other: _____	Good SPK Debris Straie DLK EI Other: _____
	Assessment	Good Unsure Enhance	Good Unsure Enhance
	Plan	RTC InS CoMg	RTC InS CoMg

Notes

Today's Date _____ Doctor's Signature

INSIGHT VISION GROUP

PRK/ASA Post-Op Evaluation

Referring Doctor: _____

Please FAX completed form to:

Parker: 720.880.6460

Boulder: 303.593.2199

Name (First/Last):	Age	Surgery Date:

Exam Data

		OD			OS		
1 Day	Goal:				Goal:		
3 Day	History	Happy	Unsure	Not Happy	Happy	Unsure	Not Happy
10 Day	Meds			AT's ____ x a day			AT's ____ x a day
1 Mo	Acuity	UCVA 20/			UCVA 20/		UCVA OU 20/
3 Mo	Refraction	20/			20/		
6 Mo		20/			20/		
Other:	Cornea						
_____	Assessment	Good	Unsure	Enhance	Good	Unsure	Enhance
	Plan	RTC		InS CoMg	RTC		InS CoMg

Doctor's Signature:	Notes:	IOP @ _____
Today's Date _____		OD _____
		OS _____

Exam Data

		OD			OS		
1 Day	History	Happy	Unsure	Not Happy	Happy	Unsure	Not Happy
3 Day	Meds			AT's ____ x a day			AT's ____ x a day
10 Day	Acuity	UCVA 20/			UCVA 20/		UCVA OU 20/
1 Mo	Refraction	20/			20/		
3 Mo		20/			20/		
6 Mo	Cornea						
Other:	Assessment	Good	Unsure	Enhance	Good	Unsure	Enhance
_____	Plan	RTC		InS CoMg	RTC		InS CoMg

Doctor's Signature:	Notes:	IOP @_____
Today's Date _____		OD _____
		OS _____