SISKIYOU EYE CENTER

Physicians, Surgeons,
and Doctors of Optometry

William S. Epstein, MD
Robert H. Ewing, MD
Jeffrey D. Welder, MD
Jared S. Fredrickson, MD
David S. England, OD

REFERRAL FORM

Fax completed form to Siskiyou Eye Center
Ashland: (541) 488-5081 Yreka: (530) 842-5839

DATE: _____
REFERRING TO: (Please indicate)
☐ Siskiyou Eye Ophthalmologist *(next available appt.)* ☐ William Epstein, MD ☐ Robert Ewing, MD
☐ Jeffrey Welder, MD ☐ Jared Fredrickson, MD ☐ David England, OD

REFERRING DOCTOR: _____

PATIENT: Last Name: _____ First Name: _____ MI: _____

Address: _____

Phone Number: (____) _____ Date of Birth: _____

PLEASE SEND A COPY OF THE PATIENT'S REGISTRATION INFORMATION WITH THIS FORM.

Examination Date: _____

Present Spec: OD _____ 20/_____ OS_____ 20/_____

Significant Medical History: _____

Dom Eye: OD / OS IOP: OD _____ OS _____

Visual Acuity w/ correction: OD 20/_____ OS 20/_____

Room Illumination / BAT: OD 20/_____ OS 20/_____

Manifest Refraction: OD _____ 20/_____ OS_____ 20/_____

Auto K Reading: OD _____ OS _____

SLE/Fundus, C/D WNL OU Abnormalities, note below

OD _____ OS _____

_____ _____

Recommendations: Cataract Surgery / YAG Laser OD / OS Appt Date: _____

Standard / Aspheric Toric Symfony Restor 2.5 No recommendation

Monivision candidate? Yes / No

Yag Laser OD OS Other:_____

Comments:

SIGNATURE: _____ DATE: _____

Ashland Office
648 N. Main Street
Ashland, OR 97520
(541) 482-8100

Yreka Office
2524 Westside Road
Yreka, CA 96097
(530) 842-2760