Everyday Eye Care

Patient referral

Fax this page to the office closest to the patient. **Urgent? Please call that office too.** We call the patient to book.

Send to

Office	Fax	Phone	Clinic days
☐ **Pasco, WA**	**(509) 543-7955**	(509) 543-7953	Mon and Thu
☐ **Sunnyside, WA**	**(509) 839-6162**	(509) 839-4575	Fri
☐ **Hermiston, OR**	**(541) 567-5407**	(541) 567-5283	Tue and Wed

Date _____ ☐ Routine ☐ Urgent (please call too)

Patient

Name _____ Date of birth _____ Phone _____

Insurance _____ Member ID _____ Interpreter needed? Language _____

Referring provider

Provider name _____ Practice _____ NPI _____

Office phone _____ Fax for our consult note _____ Contact person _____

Reason for referral

- ☐ Plaquenil (hydroxychloroquine) screening
- ☐ Diabetic eye exam
- ☐ Cataract evaluation
- ☐ Keratoconus or scleral lenses
- ☐ Children's eye exam or myopia
- ☐ Glaucoma evaluation or management
- ☐ Macular degeneration
- ☐ Dry eye or meibomian gland dysfunction
- ☐ Rabin color vision test
- ☐ Urgent eye problem
- ☐ Other high-risk medication: _____
- ☐ Other: _____

For Plaquenil or chloroquine

Daily dose _____ Start date _____ Weight _____ Kidney disease ☐ Y ☐ N Tamoxifen ☐ Y ☐ N

Diagnosis or clinical notes

Provider signature _____ Date _____

Please attach recent notes, the medication list and the insurance card if you have them. A consult note with our findings goes back to you after the visit.

Confidential: this fax contains protected health information meant only for the office named above. If you received it by mistake, please call the sender and destroy it.