

Dry-Eye Consultation Request Form



EMPIRE EYE
PHYSICIANS

REASON FOR CONSULTATION

Physician Requested

- Dr. Casey Claypool Dr. Christopher Sturbaum
 Dr. Alisha Heaton Dr. Mark Kontos Any

Location Requested (may restrict available physician)

- 1414 N Houk Rd, Spokane Valley WA 2175 N Main St, Coeur d'Alene ID

REFERRING DOCTOR INFORMATION

Name: _____

Phone: _____

Date of Exam: _____

PATIENT CONTACT INFORMATION

Name: _____

Phone: _____

Date of Birth: _____

INSURANCE INFORMATION See attached for demographics

Primary Insurance Carrier: _____ Policy: _____

Patient Address: _____

Check any that apply

Contact Lenses: Soft Rigid Scleral Worn for _____ + years

Autoimmune: The patient has a history of diagnosed autoimmune disorders
 Patient is positive for Sjogren's
 Patient has not been evaluated or is negative for Sjogren's

Cornea: Prior LASIK PRK Cross-Linking Other: _____

CLINICAL FINDINGS

Pertinent Findings: _____

Recommendation: _____

I have scheduled this patient to be seen at Empire Eye Physicians on _____

Please call to schedule patient