OREGON TRAIL EYE CENTER, PC

329 West 40th Street, Scottsbluff, NE 69361
Phone: (308)635-3911 Fax: (308)635-3130
medicalrecords@otecenter.org

REFERRAL TO OREGON TRAIL EYE CENTER

Today's Date: _____ **Referring Provider:** _____

Patient Name: _____ **Patient's DOB:** _____

Patient's Phone: _____ **Alternative Number:** _____

OTEC provider requested:

❑ Shawna Collier, MD ❑ Keegan Harkins, MD ❑ Any

Please select a preferred clinic location:

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

Please select a reason for referral:

☐ Cataract ☐ Retina ☐ Glaucoma ☐ Cornea
☐ Oculoplastics ☐ Dry Eye ☐ Uveitis ☐ Neuro-OPH
☐ Other (Please specify):_____

Testing Only | NO Exam (Please circle all that apply below):

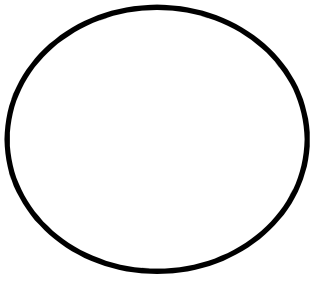
☐ OCT - Mac ☐ OCT - NFL ☐ Pachy ☐ Visual Fields ☐ Topography
☐ Other (Please Specify): _____

Clinical Details: _____

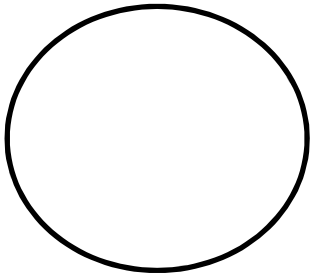
_____

Most Recent Refraction: OD: _____ 20/_____ OS: _____ 20/_____

Most Recent IOP: OD: _____ OS: _____ Method: _____



OD



OS

Please note location of defects on diagrams above.

Please send a copy of this completed form and a copy of the most recent chart note to the clinic. Send a copy with with the patient as well.
Fax to: **(308) 635-3130** or email to: ***medicalrecords@otecenter.org****

*(*Preferred method for images)*