INSTRUCTIONS FOR FILLING OUT TRIAGE FORMS

1. Referring clinician needs to fill out **BOTH** forms (PRI Information and Optometric Information).
2. Referring clinician needs to send the patients **LAST 3 FULL VISION EXAMS**. The patient's information will not be reviewed until theses have been received.
3. Fax completed forms to Stacy at 402.858.1037.
4. Ron and Dr. Heidi Wise will review the information. They will determine if the patient is appropriate for PRI Vision and the amount of time needed to evaluate the patient.
5. If you circled "Y" to the question "Clinician Permission to Contact Patient Directly?" Stacy will contact the patient to schedule the evaluation once Ron and Dr. Heidi Wise have reviewed and approved the patient to be seen by PRI Vision. If you circled "N", Stacy will contact the referring clinician prior to the patient being contacted.

INITIAL EVALUATIONS WITH INTEGRATIVE DISCIPLINES

When you are referring a patient to PRI Vision for an **initial evaluation**, please make sure your patient has not made any other appointments for an **initial evaluation** with any other integrative disciplines on the **same day**. It is recommended that the patient be seen at PRI Vision FIRST, and then follow the recommendations per the PRI Vision Staff for any other disciplines that are needed. The PRI Vision Staff will advise as to which order any other disciplines should be scheduled. If the patient is coming to PRI Vision for a **follow-up appointment**, then the patient may need to see other integrative disciplines BEFORE the appointment with Dr. Wise and a PRI Vision Physical Therapist. Thank you for your cooperation in this regard, we appreciate it.

Referring Clinician:_____
Email:_____
Phone#:_____
Clinician Permission to Contact Patient Directly Y/N

Patient Name:_____
Email:_____
Phone#:_____
Date of Birth:_____

PRI Vision Program Triage Form

Optometric Information

Wears glasses? ____Yes ____No
If yes, when? ____Full-time ____Driving/Distance ____Reading/Near ____Computer
____Other (specify): _____
If there are no glasses, have glasses been worn/recommended in the past? ____Yes ____No
If yes, for what purpose (reading, driving, etc.)? _____

Do glasses have a bifocal? ____Yes ____No
If yes, what kind? ____Lined bifocal/trifocal ____No-line bifocal ____Other (specify): _____
Wears contacts: ____Yes ____No If yes, when? ____Full-time ____Part-time
If part-time, when worn? _____
Are any glasses used while contacts are in? ____Yes ____No
If yes, for what? _____
Is the patient in monovision correction? ____Yes ____No
Type of contacts: ____Soft ____Hard/Gas Permeable ____Other (specify): _____

What is the patient's occupation?_____
How many hours per day are spent at a computer? (for business) _____(for pleasure) _____
Significant Eye/Visual History: If yes, please specify what conditions are/have been present.
Eye Disease, such as Glaucoma or Macular Degeneration? _____
Eye Trauma?_____
Eye Surgery? Please specify the procedure. _____
Eye Turn/Lazy Eye?_____
Visual Field Loss? _____
Double Vision? _____
Vision Training/Patching?_____
History of wearing prisms, and purpose? _____
Any other significant problems? _____
Are there any times that the patient is *opposed* to wearing glasses? If yes, please specify:
_____

Please write down the last prescriptions in the spaces below:
Eyeglasses: Right Eye _____
Left Eye _____

Contacts (Brand): _____

	Right Eye	Left Eye
Base Curve:		
Power:		
Other:		

Referring Clinician:_____
Email:_____
Phone#:_____
Clinician Permission to Contact Patient Directly Y/N

Patient Name:_____
Email:_____
Phone#:_____
Date of Birth:_____

PRI Vision Program Triage Form

PRI Information

What is their habitual pattern?

____ AIC (Left or Bilateral)
____ BC (Right or Bilateral)
____ TMCC
____ PEC
____ PRI Tests that are pathologic: _____

Has the patient ever been able to become neutral at the Right BC and Right TMCC? ___Yes ___No

If yes, under what conditions?
____Manual Techniques
____Non-Manual Techniques
____Closing Eye(s) or Patching
____Taking off glasses/contacts
____With glasses, but not contacts
____With contacts, but not glasses
____With Prism Use

What are the top three musculoskeletal pain patterns of the patient?

_____
_____

Previous surgery? ____Yes ____No If yes, please specify._____

Are they undergoing any other PRI-directed treatment, such as dental/orthodontic work?
____Yes ____No If yes, what care?_____

Do they have a history of:

Concussions? ____Yes ____No
Cervical Injuries, whiplash, etc? ____Yes ____No
Headaches? ____Yes ____No
Dizziness or Vertigo ____Yes ____No Has this been resolved? ____Yes ____No

Do they have an oral appliance? ____Yes ____No When is it used? ____Night ____Day
Is it a:

____NTI
____ Flat plane mandibular
____ Maxillary
____ ALF
____ other (specify): _____

Patient's Hand Dominance: Right-handed Left-handed
Anything else significant about this patient's history that would reflect the need for the patient to be seen by a P.T. and an O.D. in this PRI Vision Program?

_____
_____