

Referring Clinician: _____

Email: _____

Phone#: _____

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): _____

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: _____

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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 an oral appliance? Yes No

When is it used? Night Day

Is it a:

- NTI
- Flat plane mandibular
- Maxillary
- ALF
- other (specify): _____

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?

