

INSTRUCTIONS FOR FILLING OUT TRIAGE FORMS

1. Referring clinician needs to fill out **BOTH** forms (PRI Information and Optometric Information).
2. Fax completed forms to Kelly at (402) 467-4580.
3. 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.
4. If you circled "Y" to the question "Clinician Permission to Contact Patient Directly?" Kelly 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.
5. If you circled "N" to the above question, Kelly 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): _____

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): _____

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?

