Illinois Eye Institute Telephone Contact

Patient _____ IEI # _____ Date _____ Time _____

☐ Emergency ☐ Rx Refill ☐ Other _____ Taken By _____

Phone # : Home _____ Work _____ Pharmacy _____

Reason for Call: _____

_____

Disposition by Receptionist:
Spoke to / Left Message w/ / Paged Dr. _____ time _____

Completed by Resident / Attending:

Symptoms ☐ Pain ☐ Redness ☐ Swelling ☐ Discharge ☐ Blurred Vision ☐ Flashes ☐ Spots

When did the problem begin? _____ Is it getting worse? Y / N

Has your vision changed? Y / N How? _____ Are you diabetic? Y / N

Have you had an eye injury? Y / N What happened? _____

Advice to patient:

Instructed Patient to Make Appt for: ☐ Urgent Care _____time/date; ☐ General Exam _____time/date
☐ None ☐ Other _____time/date

Authorize Rx Refill ☐ Called / Faxed Pharmacy ☐ _____ _____
Signature Date

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