Emergency Telephone Triage Form

Courtesy Cheryl Bruce, B.A.,Opt.T.R., L.D.O.

Date/Time of Call____________Staff______________________Patient Name________________

Established pt___ New pt____Referred by________________ DOB/Age__________________

Telephone (work)_____________ (home)_____________Which eye? OD______ OS______ OU______

When did the problem begin? ____________________________

How did the problem start?______________________________

Symptoms: ___dry ___pain ___spots ___ red ___blurry ___flashes ___itchy ___discharge ___light sensitive

Has this happened before?_______________________________

Any glasses? ______ Any contact lenses?______ Diabetic?_____

Any pre-existing eye problems?___________________________

What regular medications are you taking?___________________

What eye medications are you taking?______________________

Any allergies?____

Where can we reach you now? (home/work)_________________

How soon can you arrive at the office?________________

Health insurance_______________________________________

Appointment made for__________________________________