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_____