SUBURBAN EYE CARE, P.C.
Dr. John Jacobi, OD, FCOVD | Dr. Brett Arnold, OD
32415 Five Mile Road + Livonia, MI 48154
P: 734-525-8170 + F: 734-525-0726

REFERRAL FOR SCLERAL & OTHER SPECIALTY LENSES

Date

Referred By

Address

City State Zip

Area Code Phone

Patient's Name Age

Contact Information: Caregiver/Hospital/Agency

Address

City State Zip

Area Code Phone Best time to call

NOTE: The following questions will reduce patient examination time and enable the patient to have their Scleral Lens evaluation at their initial visit. Without these answers or other supporting documentation, a comprehensive examination will be required prior to the evaluation to determine other contributing factors for decreased visual acuity.

Date of Last Eye Examination: _____

Results of Examination

BCVA: OD_____ OS_____

Previous CL Wearer?	☐ No	☐ Soft lenses	☐ RGP
Retinal Disease Affecting VA?	☐ Yes	☐ Probable/unsure	☐ No
Cataract Affecting VA?	☐ Yes	☐ Probable/unsure	☐ No
Corneal Disease Affecting VA?	☐ Yes	☐ Probable/unsure	☐ No

Diagnosis:

Suggested Evaluation For:

☐ Scleral	☐ Hybrid	☐ RGP	☐ Custom Soft
☐ Bi-Toric	☐ Bifocal	☐ Prosthetic	☐ Orthokeratology

I hereby grant permission for Suburban Eye Care, P.C. and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I hereby give permission to have this information faxed to Suburban Eye Care, P.C. so that their office can contact me (or an appointed representative) to schedule an evaluation for specialty contact lens services.

_____ _____ _____
Patient Signature Date Signature (Doctor)

* A copy of all tests results and a report will be sent to the referring doctor.