PATIENT REFERRAL INFORMATION

REFERRING PHYSICIAN INFORMATION

Referring Physician: ____________________

Phone Number: ____________________

Fax Number: ____________________

PATIENT INFORMATION

Patient Name: ____________________

Patient DOB: ____________________

Patient Phone #: ____________________

REASON FOR REFERRAL

(PLEASE INDICATE BY CHECKING BOX)

	KERATOCONUS/PELLUCID MARGINAL DEGENERATION		IRREGULAR ASTIGMATISM
	CORNEAL TRANSPLANT		HIGH REFRACTIVE ERROR
	CORNEAL SCARRING		GAS PERMEABLE LENS FITTING
	POST REFRACTIVE SURGERY (RK /LASIK/ PRK)		SOFT CONTACT LENS FITTING
	PROSTHETIC CONTACT LENS		PEDIATRIC LENS
	DRY EYE / OCULAR SURFACE DISEASE		OTHER:

ADDITIONAL COMMENTS

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Thank you for your kind referral! A comprehensive letter outlining your patient's exam and final lens parameters will be sent to the referring physician.

Stephanie L. Woo, O.D., F.A.A.O., F.S.L.S.
Scleral Lens Society Past President
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CONTACT LENS INSTITUTE OF NEVADA