CORNEA & CONTACT LENS INSTITUTE OF MINNESOTA

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Phone: 952-300-2151
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Date:_____

Referring Doctor:

Your Name: _____OD/MD

Clinic Name: _____ Phone: _____

Fax: _____

Patient Information

Name: _____ DOB: _____ Phone: _____(required)

Referral Reason

- Scleral Contact Lenses
- Keratoconus Management
- Corneal Transplant Care
- Multifocal Contact Lenses
- Prosthetic Contact Lenses
- Orthokeratology (Ortho-k)
- Myopia Control
- Dry-Eye Management
- Meibography/MiBoflow
- EyePrint PRO Custom Molded Lens

Patient Care

- **I would like to refer this patient for complete transfer of care.**
- **I would like to continue comprehensive care, please co-manage contact lenses only.**

Clinical Assessment/Diagnosis

_____

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**Please attach any exam notes/topography when applicable.

We will call your patient to schedule an evaluation/contact lens fitting with one of our doctors within 2 business days of receiving this fax. You will receive a fax with progress notes on our evaluation and plan when your patient has been seen.

Please fax completed sheet to above number.