Cornea and Contact Lens Service Referral Form

Patient Name: ________________________ DOB: __________ Phone: ____________ Exam Date: _________

Address: _________________________________ City: ___________________ State: _____ Zip: __________

Referring Physician: ________________________ Phone: ____________

*** If the patient has already been scheduled for an examination at our office, please indicate the date and time:

Date: __________ Time: __________

Reason for Referral:

Medical Referral	Refractive Referral
☐ Keratoconus	☐ Sphere
☐ Pellucid Marginal Degeneration	☐ Toric
☐ Post-Surgical / Irregular Cornea(s)	☐ Multifocal
☐ Dry Eye	☐ Gas Permeable
☐ Prosthetic	☐ Corneal Reshaping (Ortho-K)
☐ Other:	☐ Scleral lens
	☐ Other:

Details of Referral: ____

Ocular History: ____

Medical History: ____

Manifest Refraction (BCVA):

OD: ______________________________ 20/________

OS: ______________________________ 20/________

Keratometry:

OD: ________@________ ; ________@________

OS: ________@________ ; ________@________

Dominant Eye (if presbyopic): __________ Has Corneal Topography been performed? ☐ YES ☐ NO

Additional Testing / Comments: ____

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Referring Physician Signature: ____ Date: __________

Signature of Cornea and Contact Lens Faculty Member that has reviewed this referral: ______________________

**** PLEASE TURN THIS FORM INTO RHONDA ATTEBERRY'S OFFICE (ROOM 102H) ONCE COMPLETED FOR REVIEW AND SCHEDULING ****