AFFILIATE RELATIONS DEPARTMENT
Affiliate Communications Team: PHONE: (866) 399-1790
Affiliate Communications Team: FAX (517) 817-0141

REFERRING DOCTOR

Doctor Name: ________________________________ Phone #: ________________ Fax#: ________________

Practice Name/Location: ____

PATIENT

Last Name: ____ First Name: ________________________________

Phone # (H): ________________________ Phone # (W): ________________________ DOB: __________________

Appointment Date: ________________________________ Appointment Time: ______________________________

Primary Care Physician: ____________________________ Medical Insurance: ____________________________

Contact Lens Wearer: ☐ Yes ☐ No

If yes, what types: ☐ Toric ☐ Multi Focal ☐ Bi-Focal ☐ Soft ☐ Gas Perm ☐ Other______________

☐ Mono Vision – Near Eye: OD / OS Distance Eye: OD/OS What power to aim for Near:__________

How many years of contact lens wear: _________?

SEI Doctor: ________________________ **SEI Location:** ____________________________

OCULAR EXAMINATION	OD	OS
Manifest Refraction and BCVA	______________________________	______________________________
IOP	______________________________	______________________________
Anterior Segment	______________________________	______________________________
Posterior Segment	______________________________	______________________________
K's	______________________________	______________________________
Dry Eye Testing	______________________________	______________________________
Macular Imaging	______________________________	______________________________
Dominant Eye	☐	☐

DISCUSSIONS WITH PATIENT:

Implants/Procedures:

Monofocal	OD / OS	Restor 2.5 (Lifestyle)	OD / OS
Toric	OD / OS	FemtoSecond	OD / OS

Diagnosis ____

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Reason for referral: ____

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Signature of Referring Doctor / Authorized Staff: ________________________________ Date:______________