EVERGREEN EYE CENTER

Leading-edge, patient-centered care.

Corneal Crosslinking Referral Form

Fax 855-929-1515

Patient Name: _____ DOB: _____ Patient Phone: _____ ☐ M ☐ F

Medical Ins: _____ ID Number: _____ Referring Physician Contracted: ☐ Y ☐ N

Referring Physician: _____ Location: _____ Referral Date: _____

_____

_____

_____

PLEASE CHECK ONE OF THE BOXES AND PROVIDE THE REQUESTED INFORMATION OR WE WILL BE UNABLE TO SCHEDULE THE CONSULTATION:

☐ Patient has keratoconus WITH worsening refractive error.*
Please write the last two spectacle prescriptions below with approximate dates.

Old glasses prescription: _____

Recent glasses prescription: _____

☐ Patient has keratoconus WITH worsening corneal measurements.*
Please write the last two K values from topographer/autorefractor below with approximate dates.

Old keratometry values: _____

Recent keratometry values: _____

☐ Patient has keratoconus WITHOUT documented evidence of progression, monitor for progression at Evergreen Eye.

*Progression is usually defined by an increase in 1D of myopia, astigmatism, or K values.

In addition to documenting progression on this form, please also include relevant chart notes as well.