LASER VISION
LONDON

CORNEAL CROSS-LINKING (CXL) REFERRAL FORM

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REFERRING DOCTOR INFORMATION

Doctor Name _____ Billing #_____

Phone _____ Fax_____

Address _____

PATIENT INFORMATION

Last Name _____ First Name_____

D.O.B. _____ Email_____

Home Phone _____ Cell _____ Work # _____

Address _____

Currently Driving? ◯Y ◯N CTL User? ◯Y ◯N

CTL Use: ◯SCL ◯X.W. SCL ◯Toric SCL ◯RGP ◯Multifocal Rx Stable x12 Months (<0.5D change): ◯Y ◯N

Dominant Eye: ◯Right ◯Left Years of CTL Use:_____ CTL Problems? ◯Y ◯N _____

Last worn: _____ Pregnant/Nursing? ◯Y ◯N

PATIENT EVALUATION

OD: UCVA 20 /_____ BCVA 20 /_____ Pachymetry:_____ µm IOP_____ K readings: _____ /_____@_____

OS: UCVA 20 /_____ BCVA 20 /_____ Pachymetry:_____ µm IOP_____ K readings: _____ /_____@_____

Manifest Refraction: OD _____ OS _____

Cycloplegic Refraction: OD _____ OS _____

Current Prescription: OD _____ OS _____

Cornea/Lid: OD: ◯ Normal Findings: _____ OS: ◯ Normal Findings:_____

Lens: OD: ◯ Clear Findings: _____ OS: ◯ Clear Findings:_____

Retina/Macula: OD: ◯ Normal Findings: _____ OS: ◯ Normal Findings:_____

Previous Eye History (conditions, diagnosis, trauma, surgeries): ◯ None, or specify:

_____

General Health: ◯ Good ◯Uncontrolled Diabetes ◯Rheumatoid Arthritis ◯Psoriatic Arthritis ◯Lupus ◯Fibromyalgia
◯ Crohn's ◯MS ◯Ankylosing Spondilitis ◯Cancer ◯Scleroderma ◯AIDS
◯ Other Immunological Conditions ◯Other: _____