COLORADO EYE GALLERY BOULDER

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REFERRAL FOR CONTACT LENS SERVICES

Referring Doctor: _____ Date: _____

Clinic Name: _____ Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

Patient Phone: _____ Email: _____

Medical Insurance:_____ Vision Plan: _____

Treatment Goals (check all that apply): ☐ Improved BCVA ☐ Comfort ☐ Ocular Surface Support

Check all conditions that apply or are in need of consult:

- ☐ Keratoconus
- ☐ Corneal Ectasia
- ☐ Corneal Degeneration
- ☐ Post-Surgical
- ☐ Ocular Surface Disease
- ☐ Abnormal keratometry
- ☐ Frequent refractive changes
- ☐ Reduced visual acuity
- ☐ High refractive error
- ☐ Corneal scarring

Comments: _____

_____

_____

Patient Care: ☐ One-Time Consult ☐ Co-Manage Contact Lenses ☐ Transfer Complete Management

Please fax this form with your recent clinical office notes to 720-638-1223.

We will call your patient to schedule an evaluation 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.