VISION FOUNDATION

# Mission Vision Referral Form

**Patient Information**

Name ______________________ Date of Birth ______________________

Address ____________________________________________

Phone ______________________

☐ Patient seen at Lions Clinic/Falls Community Health

**Reason for consultation/referral**: (check all that apply) ☐ Cataract ☐ Glaucoma ☐ Cornea

**Chief visual complaint**: ☐ Reading ☐ Driving ☐ Hobbies ☐ Glare ☐ Other:

____________________________________________

Anything special you would like us to know about this patient:

____________________________________________

| | | OD | OS |
|---|---|---|---|
| **Current Corrected** with VA | (date _______) | 20/ ______________ | 20/ ______________ |
| **Refraction** | (date _______) | ______________ 20/ _____ | ______________ 20/ _____ |
| **IOP:** | | ______________ mm Hg | ______________ mm Hg |

**Pertinent exam findings:**

____________________________________________

____________________________________________

Ocular Surface Assessed: ☐ Yes ☐ No

Your recommendations to patients:

☐ Cataract Surgery ☐ Corneal Surgery ☐ Glaucoma

☐ Other ____________________________________________

Appointment:

☐ I would like to perform the aftercare for this patient.

Does patient have a PCP? ☐ Yes ☐ No Name: ______________________

**Referring Doctor**

Name ______________________ Phone ______________ Referral Date __________

Address ____________________________________________

Signed ______________________

Referring Doctor

**Please fax report to Vision Foundation: 605-371-7035**


**Sioux Falls, SD**
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