VANCE THOMPSON VISION

Surgical Referral Form

Patient Information

Name _____ Date of Birth _____

Address _____

Cell Phone _____ Email _____

Reason for surgical consultation: ☐ Cataract ☐ Cornea ☐ Glaucoma ☐ Refractive ☐ Eyelids ☐ Other

Surgeon referred to: _____ ☐ No Preference ☐ First Available

Location: ☐ Sioux Falls ☐ West Fargo ☐ Bozeman ☐ Omaha ☐ Alexandria ☐ Billings
☐ South Sioux City ☐ Cedar Rapids ☐ Northern Colorado ☐ Kansas City

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

_____

DOMINANT EYE (CIRCLE) OD OS	**OD**	**OS**
BEST CORRECTED VA (DATE:)	20/	20/
REFRACTION (DATE:)	20/	20/
CYCLOPLEGIC REFRACTION (with cyclogyl 1%) (See & Do Refractive Patients Only)	20/	20/
IOP	mm Hg	mm Hg
IOP MAX	mm Hg	mm Hg

Pertinent exam findings: _____

_____

Please attach exam notes, visual fields, medical insurance information, and OCTs to help us prepare for the evaluation.

Eye medications: _____

Ocular surface assessed: ☐ Yes ☐ No Management: _____

If cataract surgery is recommended: ☐ I have discussed lens options and the patient is interested in:

☐ Monofocal ☐ Advanced Implant ☐ Clinical Trial

☐ What is your desired post-op refractive target? OD _____ OS _____

☐ If monovision contact lens trial? ☐ Yes ☐ No

Appointment:

☐ This patient is already scheduled to be seen at Vance Thompson Vision on: (date) _____

☐ Please call this patient to schedule their appointment.

☐ This patient prefers See & Do if eligible.

Referring Doctor

Name _____ Referral Date _____

Address _____ Phone _____ Fax _____

FAX TO:

Sioux Falls, SD: (605) 371-7035
West Fargo, ND: (701) 639-7199
Bozeman, MT: (406) 624-6560
Omaha, NE: (402) 401-6420
Alexandria, MN: (320) 762-8898
Billings, MT: (406) 294-1996
South Sioux City, NE: (531) 625-3940
Cedar Rapids, IA: (319) 362-0655
Northern Colorado: (970) 582-1176
Kansas City: (919) 290-7692