



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: _____

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

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, and OCTs (if applicable).

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. Please do NOT schedule as a See & Do

Referring Doctor

Name _____ Referral Date _____

Address _____

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