VANCE THOMPSON VISION

Surgical Referral Form

Patient Information

Name Finn Hayes Date of Birth 12/22/2013

Address PO Box 371, Masonville, Colorado 80541

Cell Phone (970) 402-6316 Email sutersuzi2@gmail.com

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

Surgeon referred to: Dr. Ryburn

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: 09/03/26)	20/ 30	20/ 60
REFRACTION (DATE: 09/03/26)	20/ 20	20/ 20
CYCLOPLEGIC REFRACTION (with cyclogyl 1%) (See & Do Refractive Patients Only)	20/	20/
IOP	19 mm Hg	21 mm Hg
IOP MAX	24 mm Hg	24 mm Hg

Pertinent exam findings: Rule out keratoconous due to shift in corneal steepness

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 Jaclyn Munson Referral Date 09/09/26

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