Corneal Cross-Linking Consultation Request Form

EMPIRE EYE PHYSICIANS

REASON FOR CONSULTATION ❑ OU ❑ OS ❑ OD

❑ Keratoconus ❑ Pellucid Degeneration

❑ Post Refractive Surgery Corneal Ectasia ❑ Other: _____

Physician Requested ❑ Dr. Mark Kontos ❑ Dr. Christopher Sturbaum ❑ Dr. Jason Croskrey ❑ Any

REFERRING DOCTOR INFORMATION

Name: _____

Phone: _____

Date of Exam: _____

PATIENT CONTACT INFORMATION

Name: _____

Phone: _____

Date of Birth: _____

(Under 18) Guardian Name: _____

INSURANCE INFORMATION ❑ See attached for demographics

Primary Insurance Carrier: _____ Policy: _____

Patient Address:_____

IMPORTANT ❑ I have advised the patient that soft contact lenses must not be worn for a minimum of 1 week prior to consultation and/or RGP's or hard contacts for at minimum 3 weeks prior to consultation

DISEASE PROGRESSION Please include the following information via form or chart notes if available

❑ See attached for diagnostic and exam findings ❑ Will be mailed

Baseline MR: OD _____ 20/_____ OS _____ 20/_____ Date _____

Recent MR: OD _____ 20/_____ OS _____ 20/_____ Date _____

Baseline K's: OD _____@_____ _____@_____ OS _____@_____ _____@_____ Date: _____

Recent K's: OD _____@_____ _____@_____ OS _____@_____ _____@_____ Date: _____

Pertinent Findings: _____

_____

Recommendation: _____

_____

Fax form and any attached clinical documents back to (509) 928-0784