PATIENT REFERRAL for CORNEAL CROSS-LINKING

Date: ______________________ Referring OD: ___________________

Contact Person/Phone#: ___________________

PATIENT INFORMATION: (Please Print)

Patient Name: ____ Sex: ☐ M ☐ F

Street Address: ____

City: _________________________ State: ______________ Zip: _______________

Daytime Phone Number: _____________________ Cell Phone Number: ________________________

Date of Birth: _________________ Insurance: ____

Email Address: ____

Please circle all that apply:

Current Correction: Glasses Only / Hard/RGP / Daily Wear SCL / Toric SCL

Patient Rx: OD __________-___________x________ OS ___________-___________x________

Date of Keratoconus Diagnosis (approximate): _____________________

Do you feel the patient's condition is progressing? Yes / No / Unsure

Do you fit specialty contacts for Keratoconus? Yes / No

Outer island only: Are you able to manage postoperative care? Yes / No

Comments:

PLEASE SEND RECORDS FROM THE LAST 5 YEARS (if available) INCLUDING:

- **Refractions**
- **Keratometry and/or Topography**

PLEASE FAX TO: (808) 599-4818

1100 WARD AVENUE SUITE 1000 HONOLULU, HAWAII 96814 ✣ PHONE: 808.792.3937 **FAX**: 808.599.4818

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