Eye Surgeons of Indiana

Corneal Cross Linking Referral Form

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **Referral Date:** _____

Medical Insurance/Member ID: _____

Referring Doctor: _____

Practice Location: _____

☐ **Appointment Made**

Date: _____

☐ **Please Call Patient To Schedule Appointment**

Keratoconus: ☐ Diagnosed ☐ Suspect

If available, please list two prior refractions with BCVA supporting disease progression.

Please list date refraction was performed.

1.)

2.)

If available, please list two prior keratometry readings supporting disease progression.

Please list date keratometry readings were taken.

1.)

2.)

History of: ☐ RGP lens wear ☐ Scleral lens wear ☐ Refractive surgery

Recommendation for Corneal Cross-Linking? ☐ Yes

If available, please fax prior topography imaging with this form to our office at 317.579.7435.

Comments:

Please fax this form to our Referral Concierge: Fax: 317.579.7435 / Ph: 317.841.2028 SUBMIT