OCULAR SURFACE DISEASE | MYOPIA MANAGEMENT | CUSTOM CONTACT LENSES

Please fax completed form to 905.823.6666

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Date:

Patient Name/DOB/Phone/Email:

Reason for Referral:

Thank you for your referral – Additional information is required.

1. What is the BCVA?	specs ☐	CLs ☐	sc ☐
	OD	OS	
2. Last Dilated Examination? Any posterior segment disease?			
3. Is there a history of contact lens wear? yes ☐ no ☐ A: If *yes*, what kind of lenses? soft ☐ corneal GP ☐ scleral ☐ hybrid ☐ unknown ☐ B: Why was wear discontinued/unsuccessful?			
4. Is there a history of symptomatic dry eye/ocular surface disease? yes ☐ no ☐			
5. Is there a history of symblepharon or Glaucoma bleb? yes ☐ no ☐			
6. Is the patient undergoing a form of myopia management? yes ☐ no ☐ N/A ☐ A: If *yes or no*, date of last cycloplegic refraction? Rx: OD OS B: If *yes*, what type of myopia management? soft CLs ☐ orthokeratology ☐ Atropine eye drops ☐ spectacle lenses ☐ lifestyle modifications ☐			

Thank you,
Stephanie Ramdass, OD, MS, MBA, FAAO, FSLS
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