Crosslinking Referral Form

Please fax or e-mail to:

GORDON SCHANZLIN
NEW VISION INSTITUTE

Phone (858) 455-6800 Fax (858) 455-0244 e-mail rmartin@gwsvision.com

Referring Doctor_____Phone_____Date_____

Referring to: M. Gordon, M.D. D. Schanzlin, M.D. A. Gordon, M.D J. Echegoyen, M.D.

Patient Name: _____DOB_____

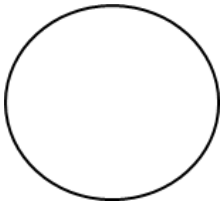
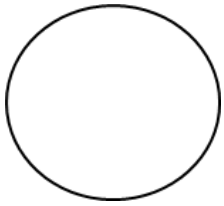
Address:_____

Phone: Home_____Cell_____

E-mail:_____Occupation:_____

Patient educated regarding: _____

Pre-Evaluation Information

	Right	***Left***
Refractive Error/ BCVA		
Cornea		
Stable or Progressive		
Keratometry		

Contact Lens History: NONE SOFT TORIC RGP Last used on: _____

Ocular History:_____

Medical History:_____

Current Medications: _____

Comments:_____

Dr's Sig: _____