Dry Eye Clinic Referral Form

Please fax or e-mail to:

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

Referring Doctor________________________Phone______________________Date_________________

Referring to: W. Gross, O.D.

Patient Name: ____DOB__________________________

Address:____

Phone: Home_____________________________________Cell__________________________________

E-mail:_________________________________Occupation:_____________________________________

Patient's main dry eye complaint:____

Pre-Evaluation Information

	Right	***Left***
BCVA		
Cornea Staining		
Meibomian Glands		
Tear Break up Time		

Contact Lens Use: NONE SOFT RGP Last used on: ____________

Ocular History:____

Medical History:____

Current Medications: ____

Dry Eye Therapies employed:____

Comments:____

Dr's Sig: ____