

# Dry Eye Clinic Referral Form

Please fax or e-mail to:

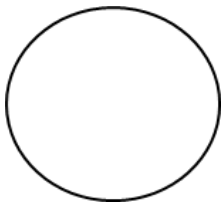
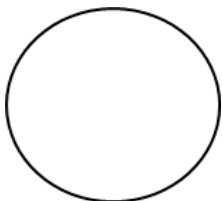


## GORDON SCHANZLIN NEW VISION INSTITUTE

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

	<i>Right</i>	<i>Left</i>
<b>BCVA</b>		
<b>Cornea Staining</b>		
<b>Meibomian Glands</b>		
<b>Tear Break up Time</b>		

**Contact Lens Use: NONE SOFT RGP** Last used on: \_\_\_\_\_

Ocular History: \_\_\_\_\_  
Medical History: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Dry Eye Therapies employed: \_\_\_\_\_  
Comments: \_\_\_\_\_  
Dr's Sig: \_\_\_\_\_