CORNEA & CONTACT LENS INSTITUTE OF MINNESOTA

Brooke Messer, OD, FAAO, FSLS
Zachary Holland, OD, FSLS

5201 Eden Ave, Suite 150
Edina, MN 55436
Phone: 952-300-2151
Fax: 952-657-5745

Date:_____

Referring Doctor:

Your Name: _____OD/MD

Clinic Name: _____ Phone: _____

Fax: _____

Patient Information

Name: _____ DOB: _____ Phone: _____

Referral Reason

- ☐ Scleral Contact Lenses
- ☐ Keratoconus Management
- ☐ Corneal Transplant Care
- ☐ Multifocal Contact Lenses
- ☐ Prosthetic Contact Lenses
- ☐ Orthokeratology (Ortho-k)
- ☐ Myopia Control
- ☐ Dry-Eye Management
- ☐ Meibography/MiBoflow
- ☐ EyePrint PRO Custom Molded Lens

Patient Care

- ☐ **I would like to refer this patient for complete transfer of care.**
- ☐ **I would like to continue comprehensive care, please co-manage contact lenses only.**

Clinical Assessment/Diagnosis

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**Please attach any exam notes/topography when applicable.

We will call your patient to schedule an evaluation/contact lens fitting with one of our doctors within 2 business days of receiving this fax. You will receive a fax with progress notes on our evaluation and plan when your patient has been seen.

Please fax completed sheet to above number.