# Corneal Cross-linking Referral

**REFERRING DOCTOR**

Name ______________________

Address ______________________

______________ Phone (___)______________

Date of exam ______________________

**PATIENT INFORMATION**

Name ______________________

Address ______________________

______________ Date of birth ______________

Phone: Hm (___)______________ Wk (___)______________

**Reason for Referral** ☐ OD ☐ OS ☐ OU

☐ Keratoconus ☐ Pellucid degeneration ☐ Post refractive surgery corneal ectasia ☐ Other ______________

**Important Notice** Soft lenses must be left out at least 7 days prior and RGPs at least 2 weeks prior to our pre-operative evaluation.

**Medical History** ______________________

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**Indications**

- In general, 15 years or older with the ability to cooperate during treatment
- Progressive corneal ectasia
- Increase in spherical and/or cylindrical component of refraction
- Decrease in best corrected visual acuity
- Topography showing alteration in corneal shape and disease progression

**Contraindications**

- Pachymetry less than 400 microns, with some exceptions
- Prior herpetic infection
- Current infection
- History of poor epithelial wound healing
- Severe ocular surface disease
- Autoimmune disorders
- Significant corneal scarring
- RGPs no longer provide reasonable vision

| **Findings That Support Progression** | **OD** | | **OS** | |
|---|---|---|---|---|
| Baseline topography (date ________) | ____@____ | ____@____ | ____@____ | ____@____ |
| ☐ Baseline topography image(s) mailed or shared electronically (please do not fax) | | | | |
| Recent topography (date ________) | ____@____ | ____@____ | ____@____ | ____@____ |
| ☐ Recent topography image(s) mailed or shared electronically (please do not fax) | | | | |
| Recent BCVA with RGP (date ______) | ________ | 20/____ | ________ | 20/____ |
| K readings and/or manifest refraction if topography is not available: | | | | |
| Baseline K readings (date ________) | ____@____ | ____@____ | ____@____ | ____@____ |
| Recent K readings (date ________) | ____@____ | ____@____ | ____@____ | ____@____ |
| Baseline manifest refraction (date ______) | ________ | 20/____ | ________ | 20/____ |
| Recent manifest refraction (date ______) | ________ | 20/____ | ________ | 20/____ |

| **Abnormal Findings** | **OD** | **OS** |
|---|---|---|
| Anterior segment | ________ | ________ |
| | ________ | ________ |
| Posterior segment | ________ | ________ |
| | ________ | ________ |

Signed ______________________
Referring Doctor

Fax this page to 360-807-7689
Electronic forms are available at www.odpcli.com

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