

BOSTON FOUNDATION for SIGHT PROSE Treatment Referral Form

Patient:

Last Name First Name DOB Phone (Best contact)

Note: Our intake staff will call your office for additional patient demographics.

Referring Physician:

Last Name First Name City State

Office Phone Office Fax Office email

Best contact method- physician to physician: phone email Best contact- correspondence: fax email USPS

Referred for PROSE: OD OS

Treatment Goals (check all that apply): Improved BCVA Comfort Ocular surface support

For Urgent Referrals please call our Physician Referral Hotline at 781-726-6033

Underlying Diagnosis(es) (check all that apply):

Ocular Surface Disease			Irregular Astigmatism / Ectasia
Stem Cell Deficiencies: Stevens Johnson syndrome/TENS Chemical burn Symblepharon within 3mm of limbus (<i>precludes fit</i>) OD OS Other: <input type="text"/>	K Sicca: Primary Sjogren's Secondary Sjogren's (condition): <input type="text"/> GVHD Post-irradiation Post-LASIK Dry eye syndrome Other: <input type="text"/>	Neurotrophic keratopathy related to: Acoustic Neuroma HSV HZV Other: <input type="text"/> Exposure: Anatomic Paralytic	Keratoconus Keratoglobus Pellucid Terrien's Post-LASIK Corneal scars Post- PK Post- RK Salzmann's Other: <input type="text"/>

Check all that apply:

Indications	Prev. Medical Interventions	Prev. Surgical Interventions
Poor best corrected vision Foreign body sensation Eye pain Photophobia GP contact lens intolerance GP contact lens fit failure Trichiasis Corneal scarring Progressive corneal neovascularization	PED active history of Superficial punctate keratitis Filamentary keratitis Injection Poor blink Lagophthalmos Anesthetic cornea Other: <input type="text"/>	Topical lubricants Restasis Topical steroids Serum tears Oral antibiotics Lid hygiene Soft contact lenses GP contact lenses Other: <input type="text"/>
		PK: OD OS Punctal occlusion Tarsorrhaphy Amniotic membrane Other: <input type="text"/>

Comments:

Important Considerations:

1. Dependent on medical equipment or personal assistant?: No Yes Describe: _____
2. Patient lives outside continental US or Canada? No Yes Country: _____
3. Case worker of any kind involved? No Yes Name/phone: _____
4. Mobility issues? No Yes Describe: _____
5. Patient age < 21? No Yes
6. Patient is in: hospital nursing home residential facility Describe: _____

Please fax your last note to the attention of New Patient Affairs at 781-726-7311 to complete this referral.