

Patient:

Last Name First Name DOB

Address:

Street City State Zip Code Country

home cell

Best Contact Phone Number Patient Email Address

Referring Physician: Last Name First Name Practice Name

Street City State Zip Code Country

Office Phone Office Fax Provider EHR Direct Message Address

Referred for PROSE: OD OS

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

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

Ocular Surface Disease		Distorted Corneas	
Stem Cell Deficiencies: <input type="checkbox"/> Chemical burn <input type="checkbox"/> Stevens Johnson syndrome / TENS Symblepharon within 3mm of limbus: OD <input type="radio"/> Yes <input type="radio"/> No OS <input type="radio"/> Yes <input type="radio"/> No If yes, precludes fit. <input type="checkbox"/> Other	K Sicca: <input type="checkbox"/> Dry eye syndrome <input type="checkbox"/> Primary Sjogren's <input type="checkbox"/> Secondary Sjogren's Condition <input type="checkbox"/> GVHD <input type="checkbox"/> Post-LASIK <input type="checkbox"/> Other	Neutrophic keratopathy: <input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> HSV <input type="checkbox"/> HZV <input type="checkbox"/> Other Exposure: <input type="checkbox"/> Anatomic <input type="checkbox"/> Paralytic Etiology	<input type="checkbox"/> Keratoconus <input type="checkbox"/> Pellucid <input type="checkbox"/> Terrien's <input type="checkbox"/> Post-LASIK <input type="checkbox"/> Corneal scars <input type="checkbox"/> Post- PK <input type="checkbox"/> Post- RK <input type="checkbox"/> Salzmann's <input type="checkbox"/> Other

Check all that apply:

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

Comments:

Important Considerations:

1. Dependent on medical equipment, O₂ or personal assistant?: No Yes Describe:
2. Case worker of any kind involved with patient? No Yes Name/phone:
3. Mobility issues? No Yes Describe:
4. Patient is: hospital inpatient in a nursing home in a residential facility Describe:

Please fax with your recent clinical office notes and insurance information to PROSE clinic at 954-465-2725.