

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

Check all that apply:

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

**Comments:****Important Considerations:**

1. Dependent on medical equipment, O<sub>2</sub> 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 312-996-4255.**