THE WILMER EYE INSTITUTE   **BostonSight® PROSE Treatment Referral Form**   Date:

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:
☐ Chemical burn
☐ Stevens Johnson
   syndrome / TENS
Symblepharon within 3mm
of limbus: OD ○ Yes ○ No
         OS ○ Yes ○ No
If yes, precludes fit.
☐ Other
	K Sicca:
	☐ Dry eye syndrome
	☐ Primary Sjogren's
	☐ Secondary Sjogren's
	Condition
	
	☐ GVHD
	☐ Post-LASIK
	☐ Other
		Neurotrophic keratopathy:
		☐ Acoustic Neuroma
		☐ HSV
		☐ HZV
		☐ Other
		
		Exposure:
		☐ Anatomic
		☐ Paralytic
		Etiology
			☐ Keratoconus
			☐ Pellucid
			☐ Terrien's
			☐ Post-LASIK
			☐ Corneal scars
			☐ Post- PK
			☐ Post- RK
			☐ Salzmann's
			☐ Other

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 ☐ Progressive corneal neovascularization ☐ Lagophthalmos	☐ PED ○ active ○ history of ☐ Superficial punctate keratitis ☐ Filamentary keratitis ☐ Poor blink ☐ Anesthetic cornea ☐ Corneal scarring ☐ Trichiasis ☐ Other	☐ Topical lubricants ☐ Restasis ☐ Topical steroids ☐ Serum tears ☐ Oral antibiotics ☐ Lid hygiene ☐ Soft contact lenses ☐ GP contact lenses ☐ Other	☐ PK: ○ OD ○ OS ☐ Punctal occlusion ☐ Tarsorrhaphy ☐ Amniotic membrane ☐ Gold weights ☐ Other

Comments:

Important Considerations:

1. Dependent on medical equipment, O_2 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 410-614-9172.

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