BOSTONSIGHT®

PROSE New Patient Referral Form

Date:_____

For Urgent/Emergent Referrals please call our Physician Referral Hotline at 781-726-7501

Patient: _____
Last Name First Name DOB

Address: _____
Street City State Zip Code Country

_____
Best Contact Phone Number ☐ home ☐ cell Patient's Email Address

Referring Physician: _____
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 ☐ HOA Correction SmartSight HOA™ ☐ 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 ectasia ☐ 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 punctuate 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 New Patient Affairs at 781-726-7311.

464 Hillside Avenue | Suite 205 | Needham, MA 02494 | 781-726-7337 *p* | 781-726-7310 *f* |www.bostonsight.org