Corneal Crosslinking Referral Sheet

Name: _____DOB: _____ Surgeon: MRB / ALM
Phone # _____

☐ Kansas City North Location
5151 NW 88th Street
Kansas City, MO 64154
P: 816.746.9800
F: 816.587.3555

☐ Lee's Summit Location
301 NW Mulberry Drive
Lee's Summit, MO 64086
P: 816.525.3937
F: 816.875.2177

☐ Manage / treat patient and return ☐Assume patient's care ☐ Second opinion only

Additional comments: _____

_____

Referring doctor: _____ Phone: _____

Location: _____ Fax: _____

Findings that support progression	**OD**	**OS**
Baseline topography K's date:	____ @ ____ ____ @ ____	____ @ ____ ____ @ ____
Recent topography K's date:	____ @ ____ ____ @ ____	____ @ ____ ____ @ ____
Recent BCVA w/ RGP date:	_____ 20/	_____ 20/
Baseline K readings date:	____ @ ____ ____ @ ____	____ @ ____ ____ @ ____
Recent K readings date:	____ @ ____ ____ @ ____	____ @ ____ ____ @ ____
Baseline MRx, CTL or Spec date: *Please circle either CTL or Spec	_____ 20/	_____ 20/
Recent MRx, CTL or Spec date: *Please circle either CTL or Spec	_____ 20/	_____ 20/

**** Mail or electronically send all records DO NOT FAX**

Abnormal Findings	**OD**	**OS**
Anterior Segment		
Posterior Segment		

For MEC use

Appointment time / date:	Scheduled by / date: