Myopia Control Referral/ Co-Management Form

Referring Doctor

Name:

Address:

Phone:

Referral Date:

Referred to:

Cheryl Chapman, OD, Dipl ABO / Sara Petska, OD

Chief visual complaint/ reason for consultation/referral:

Current Subjective refraction (if available):
Date:
OD
OS

Previous Subjective refraction (if available):
Date:
OD
OS

Keratometry Readings (if available):
OD
OS

Assessment:

If Myopia Control is recommended:

- I have discussed options and patient is interested in:
    - Ortho-K
    - Soft Dual-Focus Contacts
    - Low-Concentration Atropine Therapy
- I have not discussed options
- I am interested in co-managing this patient
    - Yes
    - No

Signed by Referring Doctor

Patient Information

Name:

DOB:

Address:

Email:

Preferred Phone:

Best Time to Call:

Ocular History:

Nearsighted:

- Yes
- No

At what age did child start wearing glasses?

Are parents Myopic?

- Both
- Mother
- Father
- Neither
- Unsure

Aside from school hours, how much time per day is spent on close/near work?

How much time is spent outdoors on an average day (including breaks at school)?

Ethnicity

- **Asian**
- **Caucasian**
- **Hispanic**
- **Other:**

Please FAX referral form & any pertinent exam records to Gretna Vision Source at 402-332-0440