BostonSight PROSE New Patient Referral Form at the Ohio State University Wexner Medical Center

Date: _____

Patient: _____
Last Name First Name DOB

Address: _____
Street City State Zip Code Country

_____
Best Contact Phone Number ☐ Cell ☐ Home 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 ☐ 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 Medical Records at 614-293-5315

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THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

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