CONLON EYE INSTITUTE

Referral Form
PH: 306-244-4111
Fax: 306-244-9904

Patient Name:		**DOB:**	**Age:**
Address:	**City:**	**Postal:**	
Home Phone:	**Cell Phone:**		
Email:			
PHN:		**Gender: Male** ☐ **Female** ☐	

Reason for referral:_____

Medical Hx/Allergies:_____

Exam Date: _____

Wearing CL today? ☐ Yes **Type:** ☐ Soft ☐ Hard ☐ RGP **Date Last Worn:**_____

UCVA
OD 20/
OS 20/

Present Correction (Age of Rx: _____)
OD _____ _____ X ____ 20/
OS _____ _____ X ____ 20/

Dominant Eye
☐ OD
☐ OS

Manifest Refraction
OD _____ _____ X _____ 20/
OS _____ _____ X _____ 20/

Cycloplegic Refraction
OD _____ _____ X _____ 20/
OS _____ _____ X _____ 20/

Pupil Size
OD _____ / _____
OS _____ / _____
Bright Dim

Corneal Thickness
OD _____
OS _____

IOP
OD _____
OS _____

Monovision Discussed ☐ **Yes** ☐ **No**

FS Laser Discussed ☐ **Yes** ☐ **No**

Comments:_____

Anterior Segment

Anterior Segment

Fundus

Fundus

Comments:	
Referring Doctor:	**Date:**