ADVANCED EYE CARE
PROFESSIONALS
Family Eye Care
CASEY L. HOGAN, O.D., F.A.A.O. & ASSOCIATES

Casey L. Hogan, O.D., F.A.A.O.
Jamie N. Lawler, O.D.
Florianne P. Burns, O.D.

Advanced Eye Care Professionals, P.C. Scleral Lens Treatment Referral Form

Date:____________________

Patient:

Last Name:

First Name:

DOB:

Phone:

Address:

Referring Physician:

Last Name:

First Name:

Practice Name:

Address:

Office Phone:

Office Fax:

Office Email:

Reason for Referral:____

Treatment OD____ OS____

Treatment GOALS:

Improved BCVA___ Comfort___

Previous Surgical Intervention:

PK:___Tarsorrhaphy:___Amnitoic Membrane:___Other:____

Dates of surgery:________________________

10320 South Cicero Avenue • Oak Lawn, Illinois, 60453
Office 708-229-2200 • Fax 708-229-2233 • www.AEPeye.com

Indications for Scleral Lens Treatment:

Check all that apply:

Stem Cell Deficiencies :___

K Sicca:

Dry eye syndrome: ___

Primary Sjogren's ___

Secondary Sjogren's ___

GVHD: ___

Post-surgical dryness: ___

Neurotrophic Keratopathy : ___

HSV: ___

HZV: ___

Other: ___

Exposure: ___

Corneal Disease:

Keratoconus :___

Pellucid MD :___

Post-PK:___

Post-RK: ___

Salzmann's:___

Corneal Scars: ___

Post-Lasik___:

Contact Lens Intolerance:___