



Corneal Cross-linking Referral

REFERRING DOCTOR

Name _____

Address _____

Phone () _____

Date of exam _____

PATIENT INFORMATION

Name _____

Address _____

Date of birth _____

Phone: Hm () _____ Wk () _____

Reason for Referral OD OS OU

Keratoconus Pellucid degeneration Post refractive surgery corneal ectasia Other _____

Important Notice Soft lenses must be left out at least 7 days prior and RGPs at least 2 weeks prior to our pre-operative evaluation.

Medical History _____

Indications

- In general, 14 years or older with the ability to cooperate during treatment
- Progressive corneal ectasia
- Increase in spherical and/or cylindrical component of refraction
- Decrease in best corrected visual acuity
- Topography showing alteration in corneal shape and disease progression

Contraindications

- Pachymetry less than 400 microns, with some exceptions
- Prior herpetic infection
- Current infection
- History of poor epithelial wound healing
- Severe ocular surface disease
- Autoimmune disorders
- Significant corneal scarring
- RGPs or scleral lens no longer provide reasonable vision

Findings That Support Progression

OD

OS

Baseline topography (date _____) @ @ @ @

Baseline topography image(s) mailed or shared electronically (please do not fax)

Recent topography (date _____) @ @ @ @

Recent topography image(s) mailed or shared electronically (please do not fax)

Recent BCVA with RGP (date _____) 20/_____ 20/_____

K readings and/or manifest refraction if topography is not available:

Baseline K readings (date _____) @ @ @ @

Recent K readings (date _____) @ @ @ @

Baseline manifest refraction (date _____) 20/_____ 20/_____

Recent manifest refraction (date _____) 20/_____ 20/_____

Abnormal Findings

OD

OS

Anterior segment _____

Posterior segment _____

Signed _____

Referring Doctor