FERRIS STATE UNIVERSITY

UNIVERSITY EYE CENTER

Cornea and Contact Lens Service Referral Form

Patient Name: _____ DOB: _____

Parent/ Guardian Name (if applicable): _____

Patient Phone Number: _____ Alternate Number: _____

Patient Address: _____

Primary Medical Insurance Name	
Policy Holder Name	
Policy Holder DOB	
Policy ID Number or Policy Holder SSN	
Primary Vision Insurance Name	
Policy Holder Name	
Policy Holder DOB	
Policy ID Number or Policy Holder SSN	
Please attach any additional insurance coverage	

Referring Physician: _____ Phone Number: _____

Reason for Referral (please check):

☐**Scleral Fitting** ☐**OrthoK** ☐ **Myopia Control** ☐**Other(please specify)** _____

Diagnosis: _____ICD-10 Diagnosis code: _____

Manifest Refraction (BCVA): Keratometry:

OD:_____20/_____ OD:_____@_____;_____@_____

OS:_____20/_____ OS:_____@_____;_____@_____

Dominant Eye (if presbyopic): _____ Has Corneal Topography been performed? Y / N

Additional Testing / Comments: _____

_____

_____

Referring Physician Signature:_____Date: _____

Please fax form with exam records to 231-591-3991. Thank You!