ALOHA LASER VISION
People Of Vision

PATIENT REFERRAL for CORNEAL CROSS-LINKING

Date: _____ Referring OD: _____

Contact Person/Phone#: _____

PATIENT INFORMATION: (Please Print)

Patient Name: _____ Sex: ☐ M ☐ F

Street Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ Insurance: _____

Email Address: _____

Please circle all that apply:
Current Correction: Glasses Only / Hard/RGP / Daily Wear SCL / Toric SCL

Patient Rx: OD _____-_____x_____ OS _____-_____x_____

Date of Keratoconus Diagnosis (approximate): _____

Do you feel the patient's condition is progressing? Yes / No / Unsure

Do you fit specialty contacts for Keratoconus? Yes / No

Outer island only: Are you able to manage postoperative care? Yes / No

Comments:

PLEASE SEND RECORDS FROM THE LAST 5 YEARS (if available) INCLUDING:

- **Refractions**
- **Keratometry and/or Topography**

PLEASE FAX TO: (808) 599-4818

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