REFERRAL FORM

Dr. Gina Wesley, OD, MS, FAAO

Dr. Joelle Holland, OD

170 Westfalen Trail, Medina MN 55340
T: (763) 478 3505
F: (763) 478 2727
E: staff@cecofmedina.com

DATE: _____

REFERRING DOCTOR

Doctor Name _____ OD/MD
Clinic Name _____
Phone _____
Fax _____

PATIENT INFORMATION

Name _____
DOB _____
Phone _____

REFERRAL REASON

- ☐ **Myopia Management Consultation**
- ☐ **Vision Therapy Consultation**
- ☐ **Dry Eye Consultation**
  - ☐ LipiFlow
  - ☐ Intense Pulsed Light (IPL)
  - ☐ Radio Frequency (RF)
  - ☐ ZEST
  - ☐ Rinsada
  - ☐ MiBo Flo
  - ☐ Low-Level Light Therapy (LLLT)
  - ☐ Lacrifill

PATIENT CARE

- ☐ Transfer care completely.
- ☐ I would like to continue care outside of above referrals.

CLINICAL ASSESSMENT

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Please include any exam notes when applicable. FAX form and records to (763) 478 2727