COMPLETE EYE CARE OF MEDINA

Gina Wesley, OD, MS, FAAO
Joelle Holland, OD

170 Westfalen Trl
Medina, MN 55340
Phone: 763-478-3505
Fax: 763-478-2727

Date: _____

Referring Doctor:

Your Name: _____OD/MD

Clinic Name: _____ Phone: _____

Fax: _____

Patient Information

Name: _____ DOB: _____ Phone: _____

Referral Reason

- ☐ Myopia Management Consultation (OrthoK/MiSight/Atropine)
- ☐ Vision Therapy Consultation
- ☐ Sports Vision Training Consultation
- ☐ Lipiflow Consultation
- ☐ Intense Pulsed Light Consultation
- ☐ General Dry Eye Consultation

Patient Care

- ☐ Transfer care completely
- ☐ I would like to continue comprehensive care, please only co-manage for referred reason.

Clinical Assessment

_____

_____

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