Central Dakota Eyecare
640 E. Sioux Ave, Pierre, SD 57501
Phone: 605-224-6128 Fax: 605-224-8446

Referral Form

Patient Name:_____DOB:_____

Patient Address:_____

Patient Phone #:_____

Medical Insurance:_____

Reason for Referral: (Please send last exam and supporting tests)

- ☐ YAG
- ☐ SLT
- ☐ Dry Eye
- ☐ Myopia Management
- ☐ Specialty Contact Lenses

Current Refraction

OD:_____ _____ x _____ = 20/_____

OS:_____ _____ x _____ = 20/_____

IOP: OD:_____ OS:_____

Ocular History:

_____

Notes:

_____

_____

_____

Referring Provider Name:_____

Referring Provider Phone #:_____Fax:_____

Date:_____