



VISION INSTITUTE NORTHWEST

T: 509-487-0600 • F: 509-487-6238 • www.VisionINW.com

Specialty Contact Lens Referral Form

Thank you for using Vision Institute Northwest for your patient's specialty Contact Lens needs. Please fill out the form below and fax the completed form along with any relevant chart notes to **509-487-6238**. We will contact the patient and schedule them for consultation and fitting at our North Spokane location.

Referring Doctor Information

Doctor Name: _____ Clinic Name: _____

Phone Number: _____ Fax number: _____

Patient Information

Patient Name: _____ DOB: _____

Name of Parent or Guardian (if applicable): _____

Phone number: _____ Email address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Medical Insurance Carrier: _____

Medical Insurance ID Number: _____

Medical Group ID: _____

Vision Insurance Carrier: _____

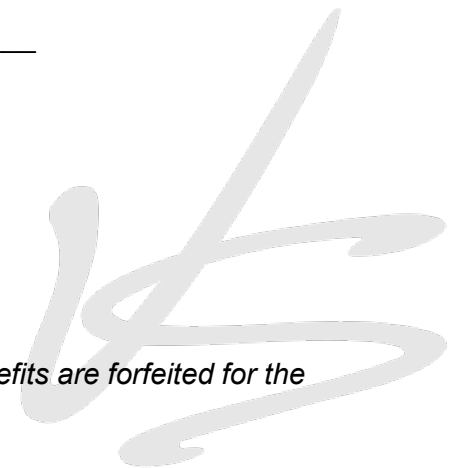
Vision Insurance ID Number: _____

Please note: For VSP, medically necessary CL fitting and hardware benefits are forfeited for the year if the hardware benefit is billed for glasses or other CLs

North Spokane
12 E Rowan Ave, Ste 1
Spokane, WA 99207

Spokane Valley
12121 E Broadway Ave, Bldg 1
Spokane Valley, WA 99206

Airway Heights
11919 W Sunset Hwy, Ste E
Airway Heights, WA 99001



Expected Type of CL Fit

- Scleral lens
- Prosthetic contact lens
- OrthoK
- Custom soft contact lens
- RGP
- Piggyback
- Hybrid
- Unsure
- Other: _____

Diagnosis (check all that apply)

- Keratoconus
- Irregular astigmatism
- Corneal Graft
- Post LASIK or RK
- Dry eye disease
- Graft-vs-Host disease
- Sjogren's syndrome
- Myopia
- Exposure keratitis
- Corneal scarring
- Other: _____

Is the patient a current CL wearer:

- Yes, type: _____
- No

Additional Notes: