Performance Vision Center
Maximizing Vision for Work, School and Sports

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DRY EYE REFERRAL

Patient Information

Full Name: Phone/Email:

Address:

Referred By:

Full Name: Phone/Email:

Address:

Address:

How Can We Support This Patient's Care?

□ Dry eye symptoms
□ Ocular surface disease
□ Contact lens intolerance
□ Redness / inflammation
□ Eyelid concerns
□ Other: _____

Any medical concerns that may be related to symptoms?

Preferred Contact Method:

☐ Phone ☐ Email:_____ ☐ Other: