Casper Vision Center

REFERRAL FORM

Patient name:_____ DOB:_____

Other contact (if needed):_____

Address:_____

Phone number:_____

Reason for Referral:

- ☐ Comprehensive eye examination
- ☐ Specialty Contact Lens
- ☐ Amniotic Membrane
- ☐ Laser Procedure (select one: ☐YAG, ☐SLT, ☐LPI)
- ☐ OptiLight IPL
- ☐ Vision Therapy
- ☐ Low Vision
- ☐ Myopia Management
- ☐ Chalazion injection/excision
- ☐ Other: _____

To see:

- ☐ Paul Gustafson, OD
- ☐ Chris Loe, OD
- ☐ Max Gustafson, OD
- ☐ Paula Kutzner, OD
- ☐ No preference

To assist in caring for your patients please include current clinical notes or patient records. This allows us to avoid repeating services.

May we contact the patient for an appointment?

- ☐ Yes
- ☐ No

Referring physician/provider:_____

Phone number:_____ Fax:_____

Please fax this completed form with pertinent records to 307-237-1370

Thank you for your referral, we look forward to working with you!