Avon Vision Dry Eye Clinic – Provider Referral Form

AVON VISION
ASSOCIATES

Referring Doctor: _____

Referring Doctor Practice Name: _____

Referring Doctor Fax Number: _____

Patient Name: _____ DOB: _____

Patient phone #: _____

Reason for Referral:

- ☐ Full Dry Eye Workup *(Always recommended if not previously seen at the practice)*
- ☐ Lumenis IPL for MGD
- ☐ Lumenis IPL for Chalazion
- ☐ Inmode Radiofrequency
- ☐ Tear Care
- ☐ Scleral Lens fit
- ☐ Amniotic Membrane
- ☐ ZEST – lid cleaning/debridement
- ☐ Punctal Plugs
- ☐ Autologous Tears
- ☐ Demodex/Blepharitis
- ☐ Neurotrophic Keratitis

Please provide any other additional information (past/current/failed treatments) along with any relevant chart notes:

We will always send your patients back to your excellent care upon completion of our involvement with their dry eye management. Thank you so much for allowing us to care for your patient.

Please fax to: **(860) 677-4836** - or- E-mail us (HIPAA protected) at **joe@avonvision.net**