MINNESOTA EYE CONSULTANTS, P.A.

The Vision Project Referral Form

Referred By: _____ **Location:** _____

Phone Number: _____ **Fax Number:** _____

Patient Name: _____ Patient DOB: _____

Patient's Primary Language: _____ Phone Number: _____

Contact Person for Patient: _____ Phone Number: _____

Patient being referred for: ❑ Cataract ❑ Glaucoma ❑ Cornea ❑ Oculoplastics

Eye(s): ❑ Right ❑ Left ❑ Both

Notes (including reason for referral, financial hardship, lack of insurance, etc.):

_____

_____

_____

_____

_____

Please fax along with most recent exam note to: 952/567-6156 (Attn: The Vision Project)

NOTE: Potential candidates will be required to thoroughly complete an application form and will need to speak with a member of our Vision Project Committee. Having an English speaking contact person is preferred, but if one is not available, please let us know so we can best be prepared to handle your patient's case in a timely manner.

If you have questions or are in need of additional information, you can contact a member of our Vision Project Committee by calling 952-346-2192 or emailing TheVisionProject@mneye.com.

We thank you as we work together to change lives, one eye at a time!

Sincerely,

The MN Eye Foundation | The Vision Project Committee