MINNESOTA EYE FOUNDATION

THE VISION PROJECT
PATIENT REFERRAL

1. PATIENT INFORMATION

FIRST NAME		**LAST NAME**	
DATE OF BIRTH	**GENDER** ☐ FEMALE ☐ MALE	**PRIMARY LANGUAGE**	**DOES THE PATIENT REQUIRE AN INTERPRETER?** ☐ YES ☐ NO
STREET ADDRESS			**APT / UNIT**
CITY, STATE, ZIP CODE		**HOME PHONE NUMBER**	**MOBILE/CELL PHONE NUMBER**
ALTERNATIVE CONTACT PERSON ***(if applicable)***		**PHONE NUMBER**	**RELATIONSHIP TO PATIENT**
PROCEDURE REQUESTED ☐ CATARACT SURGERY ☐ GLAUCOMA SURGERY ☐ CORNEAL SURGERY ☐ OTHER: ☐ CORNEAL COLLAGEN CROSSLINKING ☐ OCULOPLASTICS ☐ REFRACTIVE PROCEDURE			**EYE(S)** ☐ OD (RIGHT) ☐ OS (LEFT) ☐ OU (BOTH)

2. REFERRING PROVIDER

FIRST & LAST NAME		**NAME OF PRACTICE**
PHONE	**FAX**	**EMAIL ADDRESS**

3. ADDITIONAL INFORMATION *(if applicable)*

The Minnesota Eye Foundation accepts referrals via email and fax:

Email
TheVisionProject@mneye.com

Fax
(952) 567-6156
Attn: Minnesota Eye Foundation

Questions?
Contact the Program Administrator at (952) 346-2192.

PLEASE INCLUDE A COPY OF THE PATIENT'S MOST RECENT EYE EXAM SUMMARY.