TRUEVISION eye care

1004 Lower Shiloh Way, Suite 105
Morrisville, North Carolina
Phone: 919-472-4070
Fax: 919-472-4069

9101 Leesville Road, Suite 133
Raleigh, North Carolina
Phone: 919-629-9208
Fax: 919-364-6726

Referring Doctor:
Your Name: ____
OD/MD Clinic Name: ____
Phone: _______________________ Fax: _________________________

Patient Information
Name: ____________________________________ DOB: ____________
Phone: __________________(required)

Referral Reason

__ Scleral Contact Lenses
__ RGP/Custom Contact Lenses
__ Keratoconus/Irregular Cornea
__ Myopia Control
__ Orthokeratology
__ Multifocal Contact Lenses
__ Meibography/Dry Eye
__ Intense Pulsed Light
__ Binocular Vision

Patient Care
__ I would like to refer this patient for complete transfer of care
__ I would like to continue comprehensive care, please co-manage referred conditions only.

Clinical Assessment/Diagnosis

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Please attach any exam notes when applicable. We will call your patient to schedule an evaluation/contact lens fitting with one of our doctors within 2 business days of receiving this fax. You will receive a fax with progress notes on our evaluation and plan when your patient has been seen. Please fax completed sheet to above number.