



WARM SPRINGS
OPTOMETRIC
GROUP

To: _____
Phone # _____
Fax # _____

Date _____
Re: _____
DOB _____

Dear Doctor,

- ____ I am referring the above patient to you for care and, at his request, am forwarding the following information.
____ The above patient has come to me for complete eye care. It would be appreciated if you would provide me with the information indicated in the outline below.

Entering Glasses: Date: _____ Most Recent Refraction: Date: _____

Power	VA	Power	VA
O.D. _____		O.D. _____	
O.S. _____		O.S. _____	

Binocularity: _____

Keratometry : (Please note if change since first measured)

O.D. _____ O.S. _____

Biomicroscopy: _____

Tonometry: (Method & Time of Day) _____

Ophthalmoscopy: **O.D.** **O.S.**
C/D: _____
A/V: _____
Disc: _____
Macula: _____
Periph: _____

Visual Fields:(Method) _____

Final Contact Lens Specifications:

Material/ Brand **O.D.** _____ **O.S.** _____
Base Curve **O.D.** _____ **O.S.** _____ Diameter **O.D.** _____ **O.S.** _____
Power: **O.D.** _____ **O.S.** _____
Color: **O.D.** _____ **O.S.** _____
Visual Acuity:**O.D.** _____ **O.S.** _____
Recommended Solutions: _____

Very Sincerely Yours,

194 Francisco Lane
Suite 118
Fremont, CA 94539
(510) 490-0287
(510) 683-8891 Fax

I authorize the release of my records to Warm Springs Optometric Group.

Patient Signature: _____