VISION SOURCE®
HARBOR EYECARE CENTER

MYOPIA MANAGEMENT CENTER REFERRAL

Referring Practitioner Name: _____

Practitioner Email: _____

Practitioner Phone Number: _____ Practitioner Fax: _____

Patient Name: _____ D.O.B: _____ Gender: M / F

Parent's/Guardian: Name(s): _____

Parent's/Guardian: Email(s): _____

Parent's/Guardian Phone Number(s) : _____

The patient & parent(s) have had their questions answered regarding the consequences of treating versus not treating their child's myopia; it was explained there is ocular disease risk with increasing myopia.

Yes No

Interests in: MiSight 1 day Orthokeratology Atropine Drops with Contacts or Glasses Unsure

How old was the patient when first diagnosed with myopia? _____

Which parent is nearsighted? Mother Father Both Neither

VA sc:

OD: 20/_____ OS: 20/_____

Previous Prescription/ Date: _____

OD: _____ OD: 20/ _____

OS: _____ OS: 20/ _____

Current Prescription/ Date: _____

OD: _____ OD: 20/ _____

OS: _____ OS: 20/ _____

Please FAX Myopia Management Referral Form to: 866-694-2132

Thank you for your referral, we are committed to supporting the relationship you have with this patient and their family. We will communicate progress with you and communicate to the family that we expect the comprehensive annual examination to be performed back at your office. *-Harbor Eyecare Center's Myopia Management Team*