Corvallis Vision Center, PC
*Optometrists - Vision Specialists*
*130 SW 3rd Street, Box 926*
*Corvallis, OR 97333*
*Phone 541-757-1120 Fax 541-757-9741*

# Request for Information

_____

_____

_____ Date: _____

Patient: _____

Dear Dr. _____

☐ The above patient has come to our office for contact lens care. We would sincerely appreciate your office forwarding a copy of this patient's contact lens record, or filling out this brief form.

☐ I am referring the above patient to you for contact lens care. The following information includes the patient's basic contact lens record. If you have need of the patient's complete record please let us know.

| Date of Last Visit: | Latest "K" Readings: | Latest Spectacle Rx: | Latest Over Refraction: | VA |
|---|---|---|---|---|
| OD | / | OD | OD | 20/ |
| OS | / | OS | OS | 20/ |

Date of last lens order:

| Lens Type/Material: | Base Curve | Power | Diameter | (*OZ* | *C.T.* | *Int Curve/W* | *Int Curve/W* | *Per Curve/W*) |
|---|---|---|---|---|---|---|---|---|
| OD | | | | | | | | |
| OS | | | | | | | | |

Solution System:

Wearing Schedule: DW EW

Replacement Frequency: Daily __Weeks __Months

Remarks: _____

I authorize the release of my records to Corvallis Vision Center, PC.

Patient's Signature_____