



**Wallerich Eye Care – St. Paul**

**Address:** 1300 University Ave W  
St. Paul, MN 55104

**Telephone:** (651) 646-3163

**Fax:** (651) 646-3292

**Email:** [Michael@WallerichEyeCare.com](mailto:Michael@WallerichEyeCare.com)

**Wallerich Eye Care – Eden Prairie**

**Address:** 8225 Flying Cloud Drive  
Eden Prairie, MN 55344

**Telephone:** (952) 563-0246

**Fax:** (952) 563-0248

**Email:** [Michael@WallerichEyeCare.com](mailto:Michael@WallerichEyeCare.com)

**Specialty Contact Lens Evaluation Referral**

**EMAIL/FAX REFERRAL FORM** *(Select Preferred Location Above)*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Referred By

\_\_\_\_\_  
Address

\_\_\_\_\_  
City                      State                      Zip

\_\_\_\_\_  
Phone                      Fax

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Patient's Name                      Date of Birth

\_\_\_\_\_  
Contact Information: Parent/Guardian

\_\_\_\_\_  
Address

\_\_\_\_\_  
City                      State                      Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email Address

- Anterior Segment Photos Completed     **Yes**     **No**
- Topography of Cornea Completed         **Yes**     **No** (Check all that apply     OD     OS)
- Prior history of wear for the following (check all that apply):
  - RGPs
  - Scleral
  - Piggyback System
  - Other: \_\_\_\_\_

**Pertinent Symptoms/ History:**

\_\_\_\_\_  
\_\_\_\_\_

To refer this patient, please fax or email (HIPAA complaint email provided above) a copy of this form along with relevant records (topography/photos). Wallerich Eye Care, will reach out to schedule your patient as soon as possible. A report/copy of the exam findings will be sent back to your office if a fax number or HIPAA compliant email is provided.

Signature of Provider/Professional Referral

Date