Vision Institute

320 E Fontanero Ste 201
Colorado Springs, CO 80907
Phone: 719-559-2020
Fax: 719-632-6088

Date of Request:_____ **Referring Doctor: _____**

Referring Doctor secure email address (Required) _____

Referring Doctor's Phone:_____Fax:_____

Patient Name:_____D.O.B.:_____

Patient Phone Number:_____Insurance:_____I.D.#:_____

Reason for Consultation:_____

Diagnosis code/ICD 10:_____

Glasses RX:

OD:_____x_____ **VA cc/sc: 20/_____**

OS:_____x_____ **VA cc/sc: 20/_____**

Please circle desired testing below:

A-scan (Circle which eye) OD OS OU **B-scan (Circle which eye) OD OS OU**

Fundus Photos (in stereo at 45 and 30 degrees)

Goldman Visual Field **Optical Coherence Tomography (OCT) - Macula**

IOL Master **Optical Coherence Tomography (OCT) – Optic Nerve**

Humphrey Visual Field (Central 24-2/Central 30-2/Central 10-2/Superior 64/120 point screening)

Pachymetry **Topography**

Please circle:

Testing only: YES **Testing and Exam with Doctor: YES**

Schedule appointment: Today/ER within 2-3 days within 1 week Next available

Notes from referring physician: _____In advance, please let the patient know we will be calling them to schedule this appointment. Thank you for trusting us with your patient's ophthalmic care!

Revised 2025