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priceeyecare.com

NeuroLens Referral Form

Easy as 1 2 3

- 1 Fill out Step 1 of the form and fax to Price Eye Care at 317-318-1176
- $2-\mbox{We}$ will reach out to the patient to schedule a NeuroLens test and fax this sheet back to the referring doctor with the NeuroLens values
- $3-{\sf Fax}$ this back to us with the patient's new final Rx with NeuroLens values and we will make the patient's glasses

NeuroLens Information

- Rx parameters +/- 5.00 sphere
- SEG 18+ minimum
- It is not recommended to test patients with a history of seizures
- Patient can use their HSA
- All glasses come with anti-reflective

Step 1

Patient Name:				DOB:			
Patient Address:			-	Patient Pho	one:		
City:			_	State:		ZIP:	
Email:			_				
Preferred Date to come in	: □Monday [⊐Tuesday □Wedne	esday	□Thurs	sday 🗆	Friday	
Referring Doctor:				Practice Ph	none:		
Practice Location:				Practice Fa	ıx:		
Last Rx – with Prism and	Add if any						
OD:			Dist	ant VA 20/_	N	ear VA 20/	
OS:			Distant VA 20/		Ne	ear VA 20/	
Glasses	Material	Add Ons	-	PDs			
□SV	☐ Trivex						
□ Progressive	☐ High Index 1.67			20			
☐ Office/Computer☐ Over Contact Lenses		□ Blue Light Blocker		OS:			
Step 2 – Price Eye Care to		☐ Testing s				ate for Neurolens	
Recommended NeuroLens Value OD:							
Step 3 – Final NeuroLens							
OD:		ŗ	Prism			Add	
		·	_	Horizontal			
OS:		F	Prism _			Add	
			ŀ	Horizontal	Vertical		
Prescribing Doctor Signature:					_ Date:		

Comments

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