LASIK/PRK Surgery Patient Referral

Co-Managing Doctor

Doctor's Name: _____ Contact Person: _____
Address: _____ Office Phone: _____
City: _____ Office Fax: _____
State, Zip: _____ Emergency Ph: _____
E-Mail: _____

Patient Information

Name (Last):_____ First: _____ MI: _____
Home Phone: _____ Address:_____
Work Phone: _____ _____

D.O.B. ____/____/_____ ☐ Male ☐ Female E-Mail: _____

Patient Scheduled for Testing at Chang Eye Group: ____/____/_____ @ _____

Refractive Information

Wear: OD: _____ 20/ OS: _____ 20/ Date:
Dry: OD: _____ 20/ OS: _____ 20/ Date:
Cyclo: OD: _____ 20/ OS: _____ 20/ Date:
ADD: + _____ D
K's: OD:_____/_____@_____ OS: _____/_____@_____

Dominant Eye: ☐ OD ☐ OS

RX Stable for 12 Months (<0.50D Change)? ☐Y ☐N

Full Cycloplegic (cyclogyl) for Wet RX? ☐Y ☐N

Contact Lens Use: ☐D.W. SCL ☐ X.W. SCL ☐ Toric SCL ☐ RGP/PMMA
Power: OD:_____ OS: _____
Contacts Removed On: _____/_____/_____
The FDA recommends patients remove their CL's 2-4 weeks prior to their procedure for corneal stability. Corneal stability after CL removal will be dependent on CL fit and materials and will be measured using corneal topography and other mapping tests.

Dilation: ☐ Y ☐ N
Pachymetry: OD:_____ OS:_____
Pupils in mm (dim illumination): OD:_____ OS:_____ (in bright illumination): OD:_____ OS:_____
Binocular Testing: WNL Other Confront
VF: ABNL WNL Attached? Y/N

OD	OS
Anterior Segment:	**Anterior Segment:**
Lids/Lashes: Clear / Blepharitis	Lids/Lashes: Clear / Blepharitis
Conj: White / Injected	Conj: White / Injected
Cornea: Clear	Cornea: Clear
Neo: _____/ 4+	Neo: _____/ 4+
Dry Eye? Schirmer: _____ TBUT: _____	Dry Eye ? Schirmer: _____ TBUT: _____
Anterior Chamber:	**Anterior Chamber:**
Quiet & Deep / Shallow	Quiet & Deep / Shallow
Clear / Inflammation	Clear / Inflammation
Lenticular Opacities:	Lenticular Opacities:
IOP: _____ mm@:	IOP: _____ mm@:
Disc:	**Disc:**
□ Normal	□ Normal
□ Pale	□ Pale
□ Scleral Crescent	□ Scleral Crescent
C/D Ratio:	C/D Ratio:
Macular Reflex:	**Macular Reflex:**
□ Excellent	□ Excellent
□ Good	□ Good
□ Poor	□ Poor
Peripheral Retina:	**Peripheral Retina:**
□ Normal	□ Normal
□Thinning	□Thinning
□ Lattice/Pavingstone	□ Lattice/Pavingstone
□ Tear/Detachment	□ Tear/Detachment

Comments:

_____

_____

_____

_____

Print/Signature/Date:_____

Recommend: OD OS OU ☐LASIK ☐PRK

☐ Aim Distance OU

☐ Monovision: Distance eye: ☐OD ☐OS /Near eye: ☐OD ☐OS (Near Target: _____)

Discussed: ☐Risks/Benefits ☐Reading Post Op ☐Enhancement – 2 yr

1 Day Post Op: ☐ Referring ☐ Dr. Valli / Chang Eye Group