Refractive Surgery Referral

REFERRING DOCTOR

Name ____________________

Address ____________________

____________ Phone (____)____________

Date of Exam ____________________

PATIENT INFORMATION

Name ____________________

Address ____________________

____________ Date of Birth ____________

Phone: Hm (____)____________ Wk (____)____________

Surgery desired: ☐ LASIK ☐ PRK ☐ Refractive Lens Exchange (RLE) ☐ Implantable Contact Lens (ICL)

What refractive error outcome do you recommend for each eye? OD ____________ OS ____________

If monovision correction is indicated, has patient undergone a contact lens trial? ☐ Yes ☐ No

Reasons for interest in surgery ____________________

Occupation ____________________ Hobbies ____________________

SUBJECTIVE

Ocular history *(i.e., injury, amblyopia, previous surgery, other)* ____________________

Medical history *(i.e., diabetes, heart, lung, arthritis, lupus, pregnant, nursing, other)* ____________________

Medications: Ocular ____________________ Systemic ____________________

Allergies ____________________

OBJECTIVE

Important Note: *Accurate surgery depends on stable corneas with reliable and repeatable refractions and keratometry. At a minimum, gas perm contacts must be left out 3 weeks prior to exam and soft contacts 7 days prior.*

Dominant Eye: ☐ OD ☐ OS	**OD**	**OS**
Pupil Size *(diameter in dim light)*	______ mm APD + / - *(circle)*	______ mm APD + / - *(circle)*
VA Without Correction	20 / ______	20 / ______
Present Rx: ☐ CL ☐ Glasses (add ________)	____________ 20 /______	____________ 20 /______
Dry Refraction (*date if not today* ________)	____________ 20 /______	____________ 20 /______
Cycloplegic Refraction (*with cyclogyl 1%*)	____________ 20 /______	____________ 20 /______
Keratometry Readings: ☐ Manual ☐ Auto	______@______ ______@______	______@______ ______@______
IOP: ☐ Air ☐ Applanation	____________ mm Hg	____________ mm Hg
Central Corneal Thickness	____________ microns	____________ microns
Ocular Motility	____________	____________

Check if normal:

OD	**OS**		**OD**	**OS**	
☐	☐	Adnexa	☐	☐	Lens
☐	☐	Lids/lashes	☐	☐	Vitreous
☐	☐	Conjunctiva	☐	☐	Disc
☐	☐	Cornea	☐	☐	Vessels
☐	☐	AC	☐	☐	Macula
☐	☐	Iris	☐	☐	Periphery

Anterior segment abnormal findings ____________________

Posterior segment abnormal findings ____________________

ASSESSMENT

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PLAN

☐ I have evaluated this patient and reviewed the risks and benefits of surgery. If deemed suitable, they wish to proceed.

BILLING

☐ I have discussed the importance of post-op care and the patient understands they will be billed for follow-up services I provide.

☐ (Optional for PEN providers) Patient has agreed to pay a global fee of $__________ to Pacific Eyecare Network. This includes charges for services I have contracted with PEN to provide.

- ☐ I will collect payment and forward it to PEN.
- ☐ I would like PEN to collect $__________ at the time of surgery.

Signed ____________________
Referring Doctor

244 7/07 White copy—for your records. Yellow copy—mail or fax to PCLI Refractive Surgery Counselors at 360-807-7689.