

# Laser Vision Correction Enhancement—after 2+ years

**CATARACT AND LASER INSTITUTE**



**REFERRING DOCTOR**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Date of Exam \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Phone: Hm (\_\_\_\_) \_\_\_\_\_ Wk (\_\_\_\_) \_\_\_\_\_

Lifting LASIK flaps after two years for enhancement may increase risk of epithelial ingrowth so PRK is generally our preferred treatment beyond this time frame. We want to help patients avoid the added risk of this unpleasant complication.

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

**SUBJECTIVE**

Ocular history (*i.e., injury, amblyopia, previous surgery, cataracts, glaucoma, macular degeneration, retinal detachment, other*) \_\_\_\_\_

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

Medications: Ocular \_\_\_\_\_ Systemic \_\_\_\_\_

Allergies \_\_\_\_\_

**OBJECTIVE**

**Important Note:** Refraction must have been stable (less than .50 D change) 1 year for low to moderate myopes, 2 years for high myopes. Rigid or gas perm contacts must be left out at least 3 weeks prior to exam and soft contacts 7 days prior.

Dominant Eye:  OD  OS

	<b>OD</b>		<b>OS</b>
Pupil Size ( <i>diameter in dim light</i> )	_____ mm	APD + / - ( <i>circle</i> )	_____ mm

VA Without Correction	20 / _____	20 / _____
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Present Rx: <input type="checkbox"/> CL <input type="checkbox"/> Glasses (add _____)	_____ 20 / _____	_____ 20 / _____
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Dry Refraction ( <i>date if not today</i> _____)	_____ 20 / _____	_____ 20 / _____
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Cycloplegic Refraction ( <i>with cyclogyl 1%</i> )	_____ 20 / _____	_____ 20 / _____
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Keratometry Readings: <input type="checkbox"/> Manual <input type="checkbox"/> Auto	_____ @ _____	_____ @ _____	_____ @ _____	_____ @ _____
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IOP: <input type="checkbox"/> Air <input type="checkbox"/> Applanation	_____ mm Hg	_____ mm Hg
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Central Corneal Thickness	_____ microns	_____ microns
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Ocular Motility	_____	_____
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Check if normal:	<b>OD</b>	<b>OS</b>	<b>OD</b>	<b>OS</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anterior segment abnormal findings
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Posterior segment abnormal findings
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**ASSESSMENT**

**TERMS OF LIFETIME ENHANCEMENT AGREEMENT**

Patients qualify for free enhancement if:

- They have received the recommended follow-up care with you.
- You have shared their 1 week, 1 month, and 6 month follow-up findings with us.
- They have received yearly eye exams with you.

**PLAN**

This patient qualifies for free enhancement. If deemed suitable, they wish to proceed.