KAMRA Corneal Inlay Referral

For presbyopia correction at our Bellevue office

Pacific CATARACT AND LASER INSTITUTE

REFERRING DOCTOR

Name _____

Address _____

_____ Phone (____)_____

Date of exam _____

PATIENT INFORMATION

Name _____

Address _____

_____ Date of birth _____

Phone: Hm (____)_____ Wk (____)_____

Motivation and personality: ☐ Dislikes readers ☐ Easygoing personality ☐ Views presbyopia as disability ☐ Willing to participate in recovery

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 _____

Indications

- ☐ Age ≥ 45 years
- ☐ Spherical equivalent between plano and -0.75 with 0.75 D or less of astigmatism in the non-dominant eye (*or willing to achieve this with laser vision correction*)
- ☐ Stable refraction for minimum of 1 year
- ☐ Pachymetry > 500 microns
- ☐ Mesopic pupil size ≤ 6.0 mm

Contraindications

- ☐ Previous corneal surgery, other than laser vision correction
- ☐ Any ocular or systemic disease that is a contraindication for corneal refractive procedures (i.e. *keratoconus, poorly managed dry eye, cataracts, macular degeneration, corneal dystrophy or degeneration, amblyopia, strabismus, autoimmune disease*)
- ☐ Unrealistic post-op expectations
- ☐ Psychological conditions

★ ***Free Diagnostic Testing:*** *Send prospective patients to our office for an AcuTarget HD test to rule out significant dry eye and lens opacity. To schedule, call our Refractive Surgery Counselors at 800-884-7254.*

OBJECTIVE

Corneal stability: ☐ Soft lens wearer ☐ RGP wearer ☐ Contacts out _____ week(s) before my cycloplegic refraction.

Important Note: *For accurate surgery, soft lenses must be left out at least 7 days prior and RGPs at least 3 weeks prior, or until corneal stability is confirmed.*

	OD	OS
Dominant eye: ☐ 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 _____

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.

☐ OPTION FOR PEN PROVIDERS ONLY: Patient has agreed to pay a global fee at the time of surgery to Pacific Eyecare Network. Please collect $_____ on my behalf for the pre and/or post-op services I am contracted with PEN to provide.
Note: If you are not yet a PEN provider, but wish to utilize this fee collection service, call 800-888-1146.

Signed _____
Referring Doctor

Fax to PCLI Refractive Surgery Counselors at 360-807-7689.
Electronic forms are available at www.odpcli.com.