

# KAMRA Corneal Inlay Referral

For presbyopia correction at our Bellevue office



## REFERRING DOCTOR

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Date of exam \_\_\_\_\_

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

## PATIENT INFORMATION

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of birth \_\_\_\_\_

Phone: Hm (\_\_\_\_) \_\_\_\_\_ Wk (\_\_\_\_) \_\_\_\_\_

## 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  $\geq$  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  $\leq$  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.

Dominant eye:  OD  OS

Pupil size (diameter in dim light) \_\_\_\_\_ mm      **OD**      APD + / - (circle)      \_\_\_\_\_ mm      **OS**      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:

- |                          |                                      |                          |                                    |
|--------------------------|--------------------------------------|--------------------------|------------------------------------|
| <b>OD</b>                | <b>OS</b>                            | <b>OD</b>                | <b>OS</b>                          |
| <input type="checkbox"/> | <input type="checkbox"/> Adnexa      | <input type="checkbox"/> | <input type="checkbox"/> Lens      |
| <input type="checkbox"/> | <input type="checkbox"/> Lids/lashes | <input type="checkbox"/> | <input type="checkbox"/> Vitreous  |
| <input type="checkbox"/> | <input type="checkbox"/> Conjunctiva | <input type="checkbox"/> | <input type="checkbox"/> Disc      |
| <input type="checkbox"/> | <input type="checkbox"/> Cornea      | <input type="checkbox"/> | <input type="checkbox"/> Vessels   |
| <input type="checkbox"/> | <input type="checkbox"/> AC          | <input type="checkbox"/> | <input type="checkbox"/> Macula    |
| <input type="checkbox"/> | <input type="checkbox"/> Iris        | <input type="checkbox"/> | <input type="checkbox"/> 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