

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:

- | | | | |
|--------------------------|--------------------------------------|--------------------------|------------------------------------|
| OD | OS | OD | OS |
| <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