Refractive Surgery Referral

Pacific CATARACT AND LASER INSTITUTE

REFERRING DOCTOR

Name _____

Address _____

_____ Phone (____)_____

Date of exam _____

PATIENT INFORMATION

Name _____

Address _____

_____ Date of birth _____

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

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

IOL preference for RLE: ☐ Undetermined ☐ Single-focus ☐ Toric ☐ Multifocal

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

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

White copy—for your records. Yellow copy—mail or fax to PCLI Refractive Surgery Counselors at 360-807-7689. Electronic forms are available at www.odpcli.com.

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