

# Refractive Surgery Referral



## 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  Single-focus Toric  Extended-range-of-focus  
 Extended-range-of-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.

Dominant eye:  OD  OS

	<b>OD</b>		<b>OS</b>
Pupil size (diameter in dim light)	_____ mm	APD + / - (circle)	_____ 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 (date if not today _____)	_____ 20 / _____	_____ 20 / _____
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Cycloplegic refraction (with cyclogyl 1%)	_____ 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

### 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