

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

	OD		OS
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:	OD	OS	OD	OS	
	<input type="checkbox"/>	<input type="checkbox"/> Adnexa	<input type="checkbox"/>	<input type="checkbox"/> Lens	Anterior segment abnormal findings
	<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	Posterior segment abnormal findings
	<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	_____

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