Refractive Pre-Procedure Comanagement Evaluation

MEDICAL EYE CENTER

CO-MANAGING DOCTOR_____

PATIENT_____DOB _____ ❑M ❑F
(Last) (First)

Address_____

Cell_____Alternate #_____

Present Specs: OD_____20 /____OS_____20 /____Rx Date_____

Contact Lenses: ❑ SCL ❑ HCL ❑ Monovision – Power of lenses_____

Out for how long?_____

Significant Ocular and Medical History _____

EXAMINATION DATE_____Dominant Eye: ❑OD ❑OS

Manifest refraction: OD_____20 /_____OS_____20 / _____

Cyclo refraction: OD_____20 /_____OS_____20 / _____

SLE, Fundus, C/D ❑ WNL OU ❑ Abnormalities, note below

OD **OS**

_____ _____

RECOMMENDATIONS: ❑LASIK ❑ PRK ❑ IOL ❑ OTHER _____

❑ Bilateral ❑ OD only ❑ OS only
❑ Target Distance OU ❑ Target Mono Va

APPOINTMENT MADE: ❑ yes – Date_____ ❑ No – Please call patient

History of MRSA_____ History of Dry Eyes_____ Currently Breastfeeding_____

Comments_____

Signature_____

Fax Completed form to: 541-210-8290