PRICE VISION GROUP
REFRACTIVE SURGERY REFERRAL FORM

DATE: _____ REFERRAL DR: _____

PATIENT'S NAME : _____

ADDRESS: _____

PHONE (HOME): _____ (WORK): _____

D.O.B. _____ CO-MANAGE: YES @ 1 day 1 week 1 month NO: Return for annual exam

History of Cornea Disease (PKP or KCN) in family? YES NO
If YES, please explain: _____

PRE-OPERATIVE EVALUATION:

CURRENT RX:
OD:
OS:

GLASSES RX OVER 1 YEAR OLD:
OD:
OS:

DATE OF LAST EYE EXAM: _____

REFRACTION: VA:
OD: 20/ Vertex = _____
OS: 20/

CYCLOPLEGIC REFRACTION: VA:
OD: 20/ Vertex = _____
OS: 20/

KERATOMETRY: IOP: Pupils:
OD: OD: _____mm in light
OS: OS _____ mm in dark

SLIT LAMP EXAM:
Anterior Segment Normal: YES / NO Comments: _____

Fundus Exam Normal: YES / NO Comments: _____

CONTACT LENS INFO: Soft / Gas Permeable Hrs. Worn/Day: ___
Must be out of SCL 2 wks prior to exam; HCL or HGP out 3 wks w/ 2 stable refractions

FAX TO (317) 814-2848 ATTN. REFRACTIVE DEPT.