SightLine Laser Eye Center

# PRE-PROCEDURE EVALUATION

Please fax this form as soon as possible to 724-933-6051.

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REFERRING DOCTOR _____ EXAM DATE _____

PATIENT NAME _____ SEX: □ M □ F D.O.B. _____

PREFERRED PHONE _____ PROCEDURE DATE (if scheduled) _____

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**PREFERRED PROCEDURE TYPE** □ LASIK □ PRK

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**PAYMENT & FINANCE** I HAVE DISCUSSED FEES WITH THE PATIENT: $ _____ PER EYE.

($1975.00/eye Center Fee + $_____/eye Case-Management Fee)

PAYMENT COLLECTION (please choose one): □ Sightline □ Our Office □ Each collects own fee

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Does the patient have any **ALLERGIES TO MEDICATIONS** including analgesics, **HEALTH CONDITIONS (including pregnancy or nursing), CURRENT MEDICATIONS (including Accutane and Cordarone), PAST OR PRESENT OCULAR CONDITIONS (including Keratoconus for patient or immediate family member)** that may adversely impact the patient's procedure, outcome or long term ocular health?
□ Yes □ No If yes, list

**BASEMENT MEMBRANE DYSTROPHY?** □ Yes □ No **DRY EYE CONDITION?** □ Yes □ No If yes, explain:

**REFRACTIVE STABILITY ACHIEVED?** □ Yes □ No **RECENT CONTACT LENS WEAR?** □ Yes □ No Type:
(less than 0.50D change in 12 months)

**KERATOMETRY** OD_____ @ _____ deg. by _____ @ _____ deg.

OS_____ @ _____ deg. by _____ @ _____ deg.

**Was a cycloplegic refraction done? □ Yes □ No Was a dilated fundus exam performed? □ Yes □ No**

Please enter either: □ your recommended treatment or □ your most recent refraction

OD Sphere _____ Cyl. _____ Axis _____ VA _____ **Pachymetry** _____

OS Sphere _____ Cyl. _____ Axis _____ VA _____ _____

Desired **OUTCOME** (This will be added to or subtracted from the above prescription to achieve the desired outcome.)

OD: □ Emmetropia □ Myopia If so, what power? _____

OS □ Emmetropia □ Myopia If so, what power? _____

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**COMMENTS**:

_____ Report Faxed to SightLine Signature _____