

REFRACTIVE PRE-PROCEDURE EVALUATION

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

REFERRING DOCTOR _____ EXAM DATE _____

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

PREFERRED PHONE _____ PROCEDURE DATE (if scheduled) _____

PREFERRED PROCEDURE TYPE LASIK PRK ICL RLE ENHANCEMENT

PAYMENT & FINANCE All payments and financing will be made through Sightline according to our currently agreed upon fees.

Was a cycloplegic refraction done? Yes No If not, patient scheduled on: _____

Was a dilated fundus exam performed? Yes No

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.

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? _____

COMMENTS: