GRAND RAPIDS OPHTHALMOLOGY

Laser Vision Referral Form

Please Fax to 616.949.0375

PATIENT INFORMATION

Name _____

Address _____

Contact info (please check best method) ☐ home phone_____ ☐ work phone_____

☐ cell phone_____ ☐ email_____

Occupation: _____ Date of birth: _____ Sex (circle) **F** **M**

PROCEDURE INFORMATION

VAc̄ _____ VAs̄ _____ Pupil size _____ Light _____Dark _____

Contact Lens Use (check one) ☐ PMMA ☐ RGP ☐ SCL Date of last use_____

Current Rx (right eye) _____20/ _____ (left eye) _____20/ _____

Schirmer's Test (right eye) _____(left eye) _____ I.O.P. (right eye) _____(left eye) _____

Keratometry (right eye) _____ Flat _____ Steep _____ Steep Axis _____

(left eye) _____ Flat _____ Steep _____ Steep Axis _____

Manifest Ref (right eye) _____20/ _____ (left eye) _____20/ _____

Cyclo Ref (right eye) _____20/ _____ (left eye) _____20/ _____

Pertinent Slit Lamp (right eye) _____ (left eye) _____

Fundus (right eye) _____ (left eye) _____

Significant Medical History _____

_____

Significant Eye History _____

_____

Current Medications (steroids, etc.) _____

_____

Allergies (medications/solutions) _____

_____

Recommended Procedure (check one) ☐ Right Eye ☐ Left Eye ☐ Both Eyes

Recommended Monovision (check one) ☐ Yes ☐ No

Comments/Concerns _____

_____

SCHEDULING INFORMATIONS

Procedure Date _____ Pre-Op Date _____ Referred to _____

Doctor's Name (print) _____ (phone) _____ (fax) _____

Signature _____ Date _____

☐ I agree to provide post-operative care for this patient following Laser Vision Correction surgery and the request for Laser Vision referral form has been completed and signed by the referring doctor.