

## Pre-Operative Referral Exam

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  Male  Female  
 CC: \_\_\_\_\_

<p><b>Patient History</b></p> <p>Medical Health History: _____        _____</p> <p>Ocular Disease History: _____        _____</p> <p>H/O HSV or HZV Keratitis: <input type="checkbox"/> Y <input type="checkbox"/> N        Counseling on Pregnancy <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Allergies: _____</p> <p>Current Meds: _____</p>	<p><u>Glasses</u></p> <p>OD RX: _____ 20/        OS RX: _____ 20/        Years Worn: _____        Current Rx age: _____ years/month</p> <p><u>Contacts</u></p> <p><input type="checkbox"/> Hard <input type="checkbox"/> GP <input type="checkbox"/> Soft <input type="checkbox"/> Toric</p> <p>Years Worn: _____ Hours/Day: _____</p> <p>Date Last Worn: _____</p>
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OD Exam Results	OS Exam Results
<input type="checkbox"/>	<input type="checkbox"/>
/ @	/ @
20/	20/
20/	20/
20/	20/
20/	20/
20/	20/
IOP: Tono/App/NCT	
Dark Pupil Size (mm)	

OD Exam Results	Slit Lamp Exam	OS Exam Results
<input type="checkbox"/> Normal <input type="checkbox"/> Other:	EXT	<input type="checkbox"/> Normal <input type="checkbox"/> Other:
<input type="checkbox"/> Normal <input type="checkbox"/> Other:	CONJ	<input type="checkbox"/> Normal <input type="checkbox"/> Other:
<input type="checkbox"/> Normal <input type="checkbox"/> Other:	CORN	<input type="checkbox"/> Normal <input type="checkbox"/> Other:
<input type="checkbox"/> Normal <input type="checkbox"/> Other:	AC/IRIS	<input type="checkbox"/> Normal <input type="checkbox"/> Other:
<input type="checkbox"/> Normal <input type="checkbox"/> Other:	LENS	<input type="checkbox"/> Normal <input type="checkbox"/> Other:
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Retinal Status	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
0. cup		0. cup
<input type="checkbox"/> Cyclogyl <input type="checkbox"/> Mydracyl	Comments	<input type="checkbox"/> Cyclogyl <input type="checkbox"/> Mydracyl

OD	OS
<input type="checkbox"/> LASIK <input type="checkbox"/> Epi-LASEK/PRK <input type="checkbox"/> Cataract	<input type="checkbox"/> LASIK <input type="checkbox"/> Epi-LASEK/PRK <input type="checkbox"/> Cataract
<input type="checkbox"/> Refractive IOL <input type="checkbox"/> Other	<input type="checkbox"/> Refractive IOL <input type="checkbox"/> Other
<b>Intended Outcomes</b>	

Monovision:  Yes  No  Undecided  
 1-Day Follow-up with:  ReVision  Co-managing Doctor

Surgery Date: \_\_\_\_\_

Referring Doctor's Printed Name: \_\_\_\_\_

Referring Doctor's Signature: \_\_\_\_\_

Referring Doctor's Phone: \_\_\_\_\_