OCULAR INFORMATION

LASIK BY OCLI VISION

CO-MANAGING DOCTOR:

Doctor's Name: _____

Contact Person: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____

Email: _____

Cell Phone: _____

PATIENT INFORMATION:

Name (Last): _____ **First:** _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ Phone (Cell): _____

Email: _____

Date of Birth: _____/_____/_____ Age: _____ ☐ Male ☐ Female
Month Date Year

Patient scheduled for the following: ☐ Surgery
☐ Consult/Testing ☐ Enhancement Date: _____

REFRACTIVE INFORMATION:

Wear:	OD: _____	20/	OS: _____	20/	Date:
DRY:	OD: _____	20/	OS: _____	20/	Date:
CYCLO:	OD: _____	20/	OS: _____	20/	Date:

ADD: + _____ D K's OD: _____/_____@_____ OS: _____/_____@_____

DOMINANT EYE: ☐ OD ☐ OS RX Stable X 12 Months (<0.50 D Change)? ☐ Y ☐ N

Contact Lens Use:
☐ D.W. SCL ☐ X.W. SCL ☐ Toric SCL ☐ RGP PMMA Contacts Removed on (Date):_____

Dilation: ☐ Y ☐ N Pupils (Dim Illumination) in mm: OD: _____ OS: _____ Binocular Testing: Normal / Other

OD: ANTERIOR AND POSTERIOR EXAMINATION OS:

Anterior Chamber:
Lids/Lashes: Clear / Blepharitis
Conj: White / Injected
Cornea: Clear
Neo: _____ / 4 +

Anterior Chamber:
Quiet & Deep / Shallow
Lenticular Opacities:

IOP: _____mm @

Anterior Segment:
Lids/Lashes: Clear / Blepharitis
Conj: White / Injected
Cornea: Clear
Neo: _____ / 4 +

Anterior Chamber:
Quiet & Deep / Shallow
Lenticular Opacities:

IOP: _____mm @

Comments or other Medical / Ocular History:

VA sc OD 20/

OS 20/

Autorefraction OD

OS

Central Pachymetry

OD |_____|_____|_____|

OS |_____|_____|_____|

Schirmer 5min OD |_____|

OS |_____|

Recommend:
☐ LASIK ☐ OU ☐ OD ONLY
☐ PRK ☐ OS ONLY
☐ Aim Distance OU ☐ Aim Near OD / OS ☐ LRI
Mono Target: _____ Diopters

Discussed with patients:
☐ Risks/ Benefits ☐ Reading Post Op ☐ Enhancement

1 Day Post Operative Care to be Completed by:
☐ Surgeon ☐ Comanaging Doctor

Fees Quoted:_____ Payment Plan: ☐ Y ☐ N

Dr. Signature: _____ Print: _____ **Date:** _____