EYE CLINIC OF WISCONSIN / CO-MANAGE REFRACTIVE SURGERY REFERRAL

Date of Evaluation _____

Occupation _____

Patient Name _____

Address _____

_____

Phone # _____ (w)

_ _____ (h)

D.O.B. _____ Age _____ Male _____ Female _____

This patient is interested in:
____ LASIK
____ PRK

Reason for interest in Refractive Surgery: _____

_____

Has patient been out of CL for 2-weeks? Y N Type: _____ No. Years _____ Probs: _____ CL last worn_____

Yes	No		Yes	No		Yes	No		Yes	No	
( )	( )	Diab	( )	( )	Collagen Disease	( )	( )	AIDS	( )	( )	Cancer
( )	( )	Herpes - simplex zoster	( )	( )	Lupus	( )	( )	Keratoconus	( )	( )	Pregnant or Nursing
( )	( )	Pacemaker	( )	( )	Rheumatoid Arthritis	( )	( )	Scar Former (Keloids)	( )	( )	Are you taking? (circle)

Accutane Cordarone Norplant
Soriatane Imitrex Amerge Zomig

( ) ( ) Prism in Glasses

Does patient desire monovision? _____ yes _____ no

VSC 20/ VCC 20/ PH 20/

20/ 20/ 20/

NEAR
vsc 20/
vcc 20/
D.E. _____

K'S _____x_____/_____x_____

_____x_____/_____x_____

M/R _____+_____x_____20/_____

_____+_____x_____20/_____

C/R _____+_____x_____20/_____

_____+_____x_____20/_____

Add _____

AT _____/_____

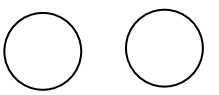
PH Prism Base

20/_____/_____/_____

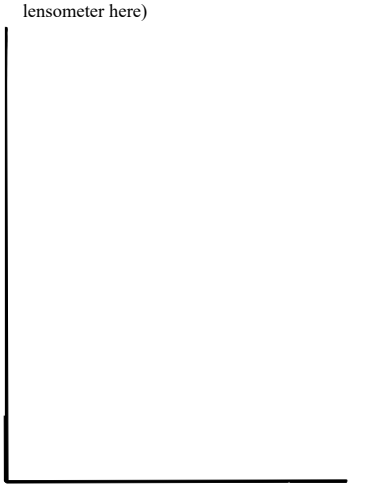
20/_____/_____/_____

VF FULL

L R



AGE OF GLASSES
SIG BIF TRI HID
(Tape present glasses Rx from lensometer here)



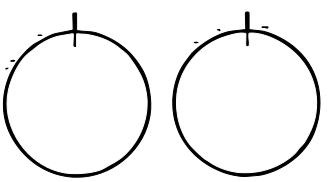
Dilation: Cyclo, OU_____ AM PM

Sungl given / sungl refused

Tech _____

Instruments Used: SL, Dir, +90 / 78, Indirect

	OD WNL	OS WNL
L,L,L,	( )	( )
MOT	( )	( )
CONJ	( )	( )
CORNEA	( )	( )
AC	( )	( )
IRIS	( )	( )
LENS	( )	( )
VIT	( )	( )
DISC	( )	( )
MAC	( )	( )
RETINA	( )	( )
Ieo Seo VESSELS	( )	( )



PACH

OD: _____ _____ _____

OS: _____ _____ _____

☐ *YES, I have agreed to co-manage by providing **pre & post**-operative care for this patient. I agree to notify Dr. Douglas T. Edwards or Dr. Afua A. Shin immediately should complications arise and to provide written progress reports during my portion of the post-operative period.*

☐ *YES, I have agreed to co-manage by providing **post**-operative care only for this patient. I agree to notify Dr. Douglas T. Edwards or Dr. Afua A. Shin immediately should complications arise and to provide written progress reports during my portion of the post-operative period.*

☐ *NO, I will not be co-managing this patient's care. Please have the Eye Clinic of Wisconsin proceed will all care, including both pre/post-operative care.*

Referring Doctor: _____

Date: _____

Please fax this completed form to: (715) 870-2401 or (715) 261-8665 or (715) 261-8671 Rev. 1/25/24