EYE CLINIC OF WISCONSIN / CO-MANAGE REFRACTIVE SURGERY REFERRAL

Date of Evaluation ____

Occupation ____

Patient Name ____

Address ____

____

This patient is interested in: ____ LASIK

____ PRK

Phone # ____ (w)

_ ______________________________________ (h)

D.O.B. ________________ Age _______ Male ______ Female _______

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. _______

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

K'S _______x_______/_______x_______

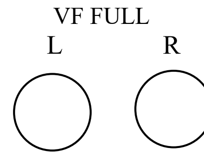
_______x_______/_______x_______

M/R ________+________x________20/_______

________+________x________20/_______

IOP _____/_____

VF FULL
L R



PH Prism Base

C/R ________+________x________20/_______

________+________x________20/_______

20/_____/_____/_____

20/_____/_____/_____

Add ______________

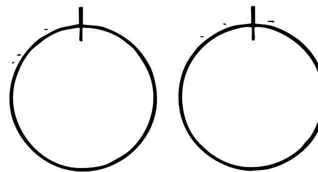
Dilation: Cyclo, OU_____________ AM PM

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 the Surgeons at the Eye Clinic of Wisconsin 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 the Surgeons at the Eye Clinic of Wisconsin 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.

Rev. 5/1/24