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**631.393.8538**

# LASIK CO-MANAGEMENT REFERRAL FORM

## COMANAGING DOCTOR

Doctor Name: _____ Contact Person: _____

Address: _____ Phone: _____

City / State / Zip: _____ Fax: _____

Preferred Contact: ☐ Phone ☐ Fax ☐ Mail ☐ Email Email Address: _____

## PATIENT

First Name: _____ Last Name: _____ M.I.: _____ Preferred Name: _____

Date Of Birth: Month: _____ Day: _____ Year: _____ Gender: ☐ Male ☐ Female

Address: _____ Home Phone: _____

City / State / Zip: _____ Work Phone: _____

Day 1 Follow-Up: ☐ Co-Managing Doctor ☐ SightMD Fee Quoted: _____ / Eye Payment Plan: ☐ Yes ☐ No

Comanagement Fee: ☐ Paid Directly to Doctor ☐ Collected PRE-OP ☐ Will Collect POST-OP ☐ MSI

## PRE-PROCEDURE EVALUATION

Ocular Surgical and Medical History:

UCVA: OD: 20 / OS: 20 / Dominant Eye: ☐ OD ☐ OS

Binocular: ☐ NL ☐ Abnormal Pupil Size (Dim illum): OD: OS:

Current RX: OD: _____ 20 / _____ OS: _____ 20 / _____ Date: _____

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

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

K's: OD: _____ / _____ @ _____ OS: _____ / _____ @ _____ RX Stable x 12 mos (S 0.50 D): ☐ Yes ☐ No

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

FDA Recommendations: Soft lenses removed 2 weeks prior to final evaluation and/or surgery day. If extended wear or soft toric, remove 3 weeks prior; RGP/PMMA remove for a minimum of 4 weeks per decade of wear. If PMMA, add two (2) weeks. Must confirm stability with refraction and topo. Center to confirm stability prior to procedure.

| Anterior Segment: | Lids/Conjunctive: | Cornea: | Lens: | IOP: | Pachymetry: |
|---|---|---|---|---|---|
| OD: | clear / Blepharitis | clear / opacities / neov. / dystrophy / dry | clear / opacities | _____ mmHg | _____ Microns |
| OS: | clear / Blepharitis | clear / opacities / neov. / dystrophy / dry | clear / opacities | _____ mmHg | _____ Microns |

| Posterior Segment: | C/D Ratio: | Myopic Degeneration: | Retina: |
|---|---|---|---|
| Dilated: Y / N | OD: 0. | none 1 2 3 4 severe | Normal / Lattice / Pavingstone / RD / holes |
| Dilated: Y / N | OS: 0. | none 1 2 3 4 severe | Normal / Lattice / Pavingstone / RD / holes |

Recommend: ☐ PRK ☐ LASIK ☐ PTK ☐ ICL ☐ Other: ☐ OD ☐ OS ☐ Bilateral ☐ Aim Distance OU ☐ Aim Near OD ☐ Aim Near OS

Mono Target: _____ D. Patient shown Mono with: ☐ Contact Lenses ☐ Trial Frame

Discussed: ☐ Benefits and Risks ☐ Presbyopia / Monovision ☐ Enhancement

Scheduled at SightMD: ☐ Surgery ☐ Consult / Additional Tests ☐ Enhancement On: ___ / ___ / ___ (month / day / year)

Comments: _____

Referring To: _____

Doctor Signature _____ Date: _____