



EVERGREEN EYE CENTER

Refractive Surgery Referral

Date of Exam: _____

Name of Patient: _____ Date of Birth: _____

Patient Phone: Home _____ Occupation: _____

Other _____ Hobbies: _____

Reason for interest in Refractive Surgery: _____

Surgery desired: LASIK ICL Refractive Lens Exchange

Surgeon: John S. Jarstad Robert A. Tester Gary W. Chung

Desired Refractive error outcome for each eye? OD _____ OS _____

If monovision is desired, has the patient undergone a contact lens trial? YES NO

Subjective

Ocular History (i.e., HSVK, Keratoconus, Corneal DX, Previous Surgery, Other) _____

Medical History (i.e., Diabetes, Lupus, Scarring, Keloids, Other) _____

Medications: _____

Allergies: _____

Objective

Stable Refraction: YES NO

Refraction must have been stable for 1 year for low to moderate myopes and 2 years for high myopes (less than .50 D change).

Contact Lenses: DWS EWS RGP

Last Worn? _____ (Soft contacts must be out 7 days and RGP contacts for 3 weeks prior to exam.)

	Right Eye	Left Eye
Dominant Eye:	<input type="checkbox"/>	<input type="checkbox"/>
Pupil Size (in dim light):	_____ mm	_____ mm
Present Rx:	_____	_____
VA:	SC 20/___ CC 20/___ NVA 20/___	SC 20/___ CC 20/___ NVA 20/___
Manifest Refraction:	_____ 20/____	_____ 20/____
Cycloplegic Refraction: (with cyclogyl 1%)	_____ 20/____	_____ 20/____
Keratometry: <input type="checkbox"/> Manual <input type="checkbox"/> Auto:	_____	_____
Anterior Segment:	_____	_____
Adnexa:	_____	_____
Lids Lashes:	_____	_____
Conjunctiva:	_____	_____
Cornea:	_____	_____
AC:	_____	_____
Iris:	_____	_____
Lens:	_____	_____
Posterior Segment:	_____	_____

Assessment: _____

Plan: _____

Physician Name: _____ Signature: _____