



The Eye Center of Fort Wayne

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REFRACTIVE SURGERY PRE-OPERATIVE REPORT

Patient Name _____ Age _____ Date _____

Occupation _____

Referring Optometrist _____

Procedure Discussed With Patient LASIK Advanced Surface Ablation
 Refractive Lens Exchange Other _____

YES I wish to assist in the post-operative management of this patient.
 NO I do not wish to assist in the post-operative management of this patient.

Additional Notes:

O.D. Signature _____

PRE-OPERATIVE EXAMINATION

Spectacle Rx is _____ years old. Stable? YES NO
Habitual Rx OD _____ 20/____ K's OD _____ / _____ @ _____
 OS _____ 20/____ OS _____ / _____ @ _____
Man. Ref. OD _____ 20/____ Cyclo. Ref. OD _____
 OS _____ 20/____ OS _____

SLIT LAMP EXAMINATION

OD Clear
 Pathology
Comments _____

OS Clear
 Pathology
Comments _____

FUNDUS EXAMINATION

OD Clear
 Pathology
Comments _____

OS Clear
 Pathology
Comments _____

IOP

OD _____

OS _____

CONTACT LENS USE: YES NO Date Last Worn _____

SCL RGP Toric SCL EWSC

Recommended for Monovision? YES Undercorrect OD / OS by _____ Diopters NO

Signature of examining doctor **X** _____