

DURRIE VISION

See a dramatic difference.

Refractive Surgery Evaluation

Pt. Name:	DOB:	Sex: M F	Exam Date:
Home Address:	City/State/Zip:		
Daytime Phone:	Mobile Phone:		

<u>Contacts:</u> None Soft RGP	<u>Total Years Worn:</u> _____
	<u>Contacts Last Worn:</u> _____

<u>Previous Ocular History:</u> N/A Other: _____
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<u>Pachs:</u> OD _____ OS _____	<u>Dominant Eye:</u> OD OS
<u>IOP:</u> OD _____ OS _____	

	<u>OD</u>	<u>OS</u>
EOM: Normal	_____	_____
CVF: FTC	_____	_____
APD: None	_____	_____
<u>Pupil Size (mm)</u>	_____	_____
Room Light:	_____	_____
Dim Light:	_____	_____
Schirmer's Test:	_____ mm/5min	_____ mm/5min

<u>VA SC:</u>	<u>Dist:</u>	OD: 20/ _____	OS: 20/ _____	OU: 20/ _____
	<u>Near:</u>	OD: 20/ _____	OS: 20/ _____	OU: 20/ _____
<u>Manifest Rx:</u>	OD	_____ x _____	= 20/ _____	
	OS	_____ x _____	= 20/ _____	
<u>Cyclo Rx:</u>	OD	_____ x _____	= 20/ _____	
<u>Required</u>	OS	_____ x _____	= 20/ _____	
<u>K's:</u>	OD	_____ @ _____ / _____ @ _____		
	OS	_____ @ _____ / _____ @ _____		

		<u>Slit Lamp Exam</u>	
		<u>OD</u>	<u>OS</u>
External/Lids	WNL	_____	_____
Conjunctiva	WNL	_____	_____
Cornea	WNL	_____	_____
Lens	Clear	_____	_____
		Type/Grade	Type/Grade
		<u>OD</u>	<u>OS</u>
Disc	WNL	C/D: _____	C/D: _____
Macula	WNL	_____	_____
Periph	WNL	_____	_____

<u>Procedure(s)</u>	OD:	SBK/LASIK	ASA/PRK	CK	Refractive Lens Exchange	Phakic IOL
<u>Discussed with Patient:</u>	OS:	SBK/LASIK	ASA/PRK	CK	Refractive Lens Exchange	Phakic IOL

Doctor Name:	_____
Office Address:	_____

Office Phone:	_____
Office Fax:	_____
Contact Person:	_____
Doctor Signature:	_____

<u>Notes</u>

Please fax to: 913-491-9650 ATTN: Refractive Surgery Counselor
 5520 College Blvd Ste 201, Overland Park, KS 66211 Phone: (913)491-3330