SASK LASER VISION

DATE *(MM/DD/YYYY)*: _____

Refractive Surgery Referral Form

PATIENT INFORMATION	**CO-MANAGING DOCTOR INFORMATION**
Name:	Doctor Name:
DOB *(MM/DD/YYYY)*:	Clinic Name:
Email:	
Phone #:	Phone #:
Address:	Fax #:

CLINICAL INFORMATION

Ocular History:	Medical History:
Medications:	Pertinent Family History:
Allergies:	CL wear:
Ocular Dominance:	Occupation:
Reason for Referral: Corneal surgery: ☐ SMILE ☐ LASIK ☐ PRK ☐ Presbyond ☐ Monovision Lens surgery: ☐ RLE ☐ Toric ☐ EDOF ☐ Trifocal	

	OD		OS	
Unaided Visual Acuity				
Subjective Refraction		20/		20/
Previous Refraction *Year:*		20/		20/
Cycloplegic Refraction*		20/		20/
Stable Refraction**	☐ Yes ☐ No		☐ Yes ☐ No	
Keratometry				
Pachymetry *(µm)*				
IOP *(mmHg)*				
Anterior Segment				
Posterior Segment				

** Recommended for all hyperopic refractions and enhancements* ***Refractive stability is considered less than 0.5 DS change in 2 years*

☐ I agree to participate in the co-management of this patient's care with Sask Laser Vision Solutions.

Comments/Signature: