



fax to 855-598-6850

Pre-Operative Assessment

PATIENT INFORMATION

Last Name	First Name	Birthdate / /	Age	Eye Color
Address	City	State	Zip Code	
Evening Phone ()	Daytime Phone ()	Cell Phone ()		
Email	Fee quoted per eye	Date of Dilated Exam / /		

DOCTOR'S REQUEST FOR ACTION

Schedule Measurements
 Call Patient and Schedule Surgery Date
 Patient Requests Sedative for Surgery
 Surgery is Scheduled for / /

MEDICAL & OCULAR HISTORY

Medical Conditions	Ocular Conditions (previous eye surgeries, refractive procedures, diseases, injuries)
Current Medications (if applicable)	Allergic Reactions (medications, solutions)
Contact Lens Use # of Years: _____	<input type="checkbox"/> RGP <input type="checkbox"/> TORIC SCL <input type="checkbox"/> DWSCl <input type="checkbox"/> EWSCl Time out of CLs

PROCEDURE ASSESSMENT

OD

OS

Unaided Visual Acuity	20/	20/
Best Corrected Visual Acuity	20/	20/
Manifest Refraction	20/	20/
Cycloplegic Refraction	20/	20/
Stable Refraction	Mos Yrs Unknown	Mos Yrs Unknown
Keratometry	Flat @ Axis Steep @ Axis	Flat @ Axis Steep @ Axis
IOP	mmHG @	mmHG @
Slit Lamp	<input type="checkbox"/> Normal <input type="checkbox"/> Other	<input type="checkbox"/> Normal <input type="checkbox"/> Other
Pupil Diameter	(mm) Dim (mm) Bright Illumination	(mm) Dim (mm) Bright Illumination
Fundus / Peripheral Retina	normal lattice pavingstone RD holes abnormal	normal lattice pavingstone RD holes abnormal
Central Pachymetry	microns	microns
Recommended Procedure	<input type="checkbox"/> Advanced <input type="checkbox"/> PRK <input type="checkbox"/> LASIK <input type="checkbox"/> Enhancement <input type="checkbox"/> Cataract <input type="checkbox"/> RLE	<input type="checkbox"/> Advanced <input type="checkbox"/> PRK <input type="checkbox"/> LASIK <input type="checkbox"/> Enhancement <input type="checkbox"/> Cataract <input type="checkbox"/> RLE
Mono-vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dominant Eye <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> ALT
Targeted Post-Op Refraction		

Comments/Questions

I agree to provide pre-op exam(s) and post-op care to this patient. I will notify Dr. Furlong immediately if complications arise and to provide written post-op reports.

I will bill the patient's insurance (e.g. Medicare, PPOs) for post-op care. Yes No

Practice Name	Optometrist Name	Signature
Practice Address	Phone number	Fax number