FURLONG VISION CORRECTION

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: _____ ☐ RGP ☐ TORIC SCL ☐ DWSCL ☐ 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	☐ Normal ☐ Other	☐ Normal ☐ 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	☐ LASIK ☐ PRK ☐ Enhancement	☐ LASIK ☐ PRK ☐ Enhancement
	☐ Cataract ☐ RLE ☐ ICL	☐ Cataract ☐ RLE ☐ ICL
Monovision	☐ Yes ☐ No	Dominant Eye ☐ OD ☐ OS ☐ 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