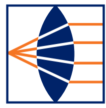

GRAND RAPIDS OPHTHALMOLOGY

Eye Care | Surgery | Laser Correction

Laser Vision Referral Form

Please Fax to 616.949.0375

See every moment.®

PATIENT INFORMATION

Name ______

Address ______

Contact info (please check best method) ☐ home phone ______ ☐ work phone ______

☐ cell phone ______ ☐ email ______

Occupation ______ Date of Birth ______ Sex (circle) M F

PROCEDURE INFORMATION

VAc̄ ______ VAs̄ ______ Pupil size ______ Light ______ Dark ______

Contact Lens Use (check one) ☐ PMMA ☐ RGP ☐ SCL Date of last use ______

Current Rx (right eye) ______ 20/ ______ (left eye) ______ 20/ ______

Schirmer's Test (right eye) ______ (left eye) ______ **I.O.P.** (right eye) ______ (left eye) ______

Keratometry (right eye) ______ Flat ______ Steep ______ Steep Axis ______

(left eye) ______ Flat ______ Steep ______ Steep Axis ______

Manifest Ref (right eye) ______ 20/ ______ (left eye) ______ 20/ ______

Cyclo Ref (right eye) ______ 20/ ______ (left eye) ______ 20/ ______

Slit Lamp (right eye) ______ 20/ ______ (left eye) ______ 20/ ______

Fundus (right eye) ______ 20/ ______ (left eye) ______ 20/ ______

Significant Medical History ______

Significant Eye History ______

Current Medications (steroids, etc.) ______

Allergies (medications/solutions) ______

Recommended Procedure (check one) ☐ Right Eye ☐ Left Eye ☐ Both Eyes

Recommended Monovision (check one) ☐ Yes ☐ No

Comments/Concerns ______

SCHEDULING INFORMATIONS

Procedure Date ______ Pre-Op Date ______ Referred to ______

Doctor's Name (print) ______ (phone) ______ (fax) ______

Signature ______ Date ______