

# Laser Enhancement Consultation Request Form – 2+ Years Following Refractive Surgery



**EMPIRE EYE**  
PHYSICIANS

**REASON FOR CONSULTATION**    OU    OS    OD

Physician Requested    Dr. Mark Kontos    Dr. Christopher Sturbaum    Any

## REFERRING DOCTOR INFORMATION

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

## PATIENT CONTACT INFORMATION

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**INSURANCE INFORMATION**    See attached for demographics

Primary Insurance Carrier: \_\_\_\_\_   Policy: \_\_\_\_\_

Patient Address: \_\_\_\_\_

### Check any that apply

Contact Lenses:    Soft    Rigid

Other Diagnoses:    Dry-Eye or Meibomian Gland Dysfunction  
 Amblyopia  
 Corneal Disease: \_\_\_\_\_

Monovision:    Patient has monovision correction

Prior Surgery:    LASIK    PRK    Other: \_\_\_\_\_  
 *Previously hyperopic*  
 *Previously myopic*

Co-managing:    *Patient will continue post-op care at my office*  
 *Patient will continue post-op care with Empire Eye Physicians*

**IMPORTANT**    I have advised the patient that soft contact lenses must not be worn for a minimum of 1 week prior to consultation and/or RGP's or hard contacts for at minimum 3 weeks prior to consultation

**CLINICAL FINDINGS**   Please include the following information if available

See attached for diagnostic and exam findings    Will be mailed

Manifest Refraction: OD \_\_\_\_\_ 20/\_\_\_\_   OS \_\_\_\_\_ 20/\_\_\_\_   Date \_\_\_\_\_

Cyclo Refraction:   OD \_\_\_\_\_ 20/\_\_\_\_   OS \_\_\_\_\_ 20/\_\_\_\_   Date \_\_\_\_\_

Pertinent Findings: \_\_\_\_\_

Recommendation: \_\_\_\_\_