Refractive Surgery Consultation Request Form

EMPIRE EYE
PHYSICIANS

REASON FOR CONSULTATION ❑ OU ❑ OS ❑ OD

❑ LASIK ❑ PRK ❑ ICL ❑ Other: ___________________________

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: ______________________________

(Under 18) Guardian Name: ___________________________________

INSURANCE INFORMATION ❑ See attached for demographics

Primary Insurance Carrier: ____________________________ Policy: ___________________________________

Patient Address: ____

Check any that apply

Contact Lenses: ❑ Soft ❑ Rigid Worn for ___________ + years

Other Diagnoses: ❑ Dry-Eye or Meibomian Gland Dysfunction
❑ Amblyopia
❑ Corneal Disease: ______________________________

Monovision: ❑ Patient has monovision correction
❑ *Recommended or candidate for monovision LASIK*

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: ____

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Recommendation: ____

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Fax form and any attached clinical documents back to (509) 928-0784