Refractive Surgery Consultation Request Form

REASON FOR CONSULTATION ❑ OU ❑ OS ❑ OD

❑ LASIK ❑ PRK ❑ ICL ❑ Other: _____

Physician Requested ☐ Dr. Mark Kontos ☐ Dr. Christopher Sturbaum
☐ Dr. Jason Croskrey ☐ Any

REFERRING DOCTOR INFORMATION

Name: _____

Phone: _____

Date of Exam: _____

PATIENT CONTACT INFORMATION

Name: _____

Phone: _____

Date of Birth: _____

Address: _____

_____

INSURANCE INFORMATION ❑ See attached for demographics

Primary Insurance Carrier: _____ Policy: _____

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 2 weeks prior to consultation and/or RGP's or hard contacts for at minimum 4 weeks prior to consultation

CLINICAL FINDINGS Please include the following information if available

❑ See attached for diagnostic and exam findings ❑ Will be mailed

Pertinent Findings: _____

_____

Recommendation: _____

_____

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