

Refractive Surgery Exam Sheet

Patient name: _____ Date: _____ Age: _____

Allergies: _____

Patient Goals: _____

Contact Lens Hx: None Type: ___ Soft ___ RGP ___ PMMA ___ Toric ___ DW ___ EW

Last Worn: _____ Wearing Hx: ___ Years H/O Dry Eye CL Intolerance GPC K Ulcer Infection

Pregnant/Nursing Y/N Medication Hx: Accutane Y/N Cordarone Y/N Imitrex/Zomig Y/N

VA C/C OD _____ NEAR VA C/C OU _____
OS _____ Bifocal Yes/No

VA S/C OD _____ NEAR VA S/C OU _____
OS _____

MEDICATION	OD	OS	OU

Dominant Eye: _____

Current Rx: Age of Current Rx _____

OD _____ 20/

OS _____ 20/

ADD+ _____

MR:

OD _____ 20/

OS _____ 20/

ADD+ _____

CR:

OD _____ 20/

OS _____ 20/

PUPILS:

OBJECTIVE

Light: OD ___ OS ___ mm

Dark: OD ___ OS ___ mm

IOP: Tap OD _____

OS _____

A/C _____

RAPD _____

CMN OU @ _____



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CONSENT FOR COMANAGEMENT AFTER LASIK SURGERY

Patient Name: _____ Date: _____

Dr. Michelle Akler will be performing _____ on my Right/Left eye. It is my desire to have _____ to perform my postoperative follow-up care. I understand that _____ will contact Dr. Akler immediately if I experience any complications related to my LASIK Surgery. I also understand that I may contact Dr. Akler at any time after the surgery.

Patient: _____ Date: _____

Witness: _____ Date: _____

OPTOMETRIST CONFIRMATION

I have agreed to provide follow-up care on _____. I will see the patient after LASIK Surgery when Dr. Akler notifies me that she is releasing the patient to my care. I agree to notify Dr. Akler immediately should any complications arise and to provide her with written progress reports during my portion of the postoperative period.

Physician Signature: _____ Date: _____