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 Ye Medication Hx: Accutane Y/N Yes Cordarone Y/N Yes Imitrex/Zomig Y/N Yes

VA C/C OD_____ NEAR VA C/C OU _____

OS_____ Bifocal Yes/No Yes

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 @_____

2841 Monroe Street, Suite 1
Dearborn, MI 48124
T 313.563.EYES (3937)
F 313.563.3930

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: _____