



Refractive Surgery Assessment & Referral

PLEASE PRINT or TYPE

Assessment Date (m/d/y): \_\_\_\_\_

Patient Name (Dr./Mr./Mrs./Ms./Miss): \_\_\_\_\_ Sex:  Female  Male

DOB (m/d/y): \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov/State: \_\_\_\_\_ Postal/Zip: \_\_\_\_\_

Telephone (res): \_\_\_\_\_ Telephone (bus): \_\_\_\_\_ Telephone (cell): \_\_\_\_\_

Name of Doctor Assessing: \_\_\_\_\_

Telephone: \_\_\_\_\_ City: \_\_\_\_\_

Patient History

Ocular History (e.g., Injury, Amblyopia, Previous Eye Surgery Dry Eye, Motivation for surgery, etc.): \_\_\_\_\_

Medical History: \_\_\_\_\_

Please Check:  Diabetes  Vascular Disease  Ocular Herpes Simplex/Zoster  Pregnancy/Nursing
 Collagen  Auto Immune  Other (please specify): \_\_\_\_\_

List Medications, include Imitrex® (migraine), Accutane® (acne), Amiodarone® (cardiac anti-arrhythmic) &/or Flomax® (urinary flow):

Ocular: \_\_\_\_\_ Systemic: \_\_\_\_\_

Current Spectacles Rx OD \_\_\_\_\_ OS \_\_\_\_\_

Prism:  Yes  No Eye Dominance:  OD  OS

Current Contact Lens Rx OD \_\_\_\_\_ OS \_\_\_\_\_

If contact lenses are worn, indicate:  Soft  RGP  Monovision Simulated

Refraction Date: \_\_\_\_\_ OD \_\_\_\_\_ OS \_\_\_\_\_

Vertex Distance: \_\_\_\_\_ 20/ \_\_\_\_\_ 20/ \_\_\_\_\_

Keratometry Readings  Manual  Auto \_\_\_\_\_

Pupil Size (Diameter in dim illumination) \_\_\_\_\_ mm \_\_\_\_\_ mm

Best Corrected Visual Acuity \_\_\_\_\_

Anterior Segment \_\_\_\_\_

Posterior Segment  Dilated  Undilated \_\_\_\_\_

C/D (Cup-to-disc ratio) \_\_\_\_\_

Macula \_\_\_\_\_

Periphery \_\_\_\_\_

Pachymetry \_\_\_\_\_

Monovision Discussed  Yes  No Contact Lens Monovision Trial Completed  Yes  No

Comments: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_

Gimbel Eye Centre Calgary Fax: (403) 202-3303

Gimbel Eye Centre Edmonton Fax: (780) 452-4114