GIMBEL EYE CENTRE

# Refractive Surgery Assessment & Referral Form

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 | _____ | _____ |
| Crystalline Lens | _____ | _____ |
| 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) 286-2943



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