# Spivack Vision Center®

6881 S. Yosemite St.
Centennial, CO 80112
(303) SEE-2020 fax: (303) 740-8344

Patient's Name:_________________________________Ref. Doctor: ______________________
Pat.'s Birthdate: ______________Age:____ Ref. Doctor's office number:______________________
Pat.'s phone number:__________________Ref. Doctor's fax number:________________________

## REFERRAL / PREOP FORM

Binocularity: ☐ wnl ☐ ____________ Eye Dominance: ☐ OD ☐ OS Pupils (bright/dim): _____/_____ OD

Contact Lens History: Type:__________ Years Worn:______ Last Removed:________ _____/_____OS

Medical History: ☐ Rheumatoid Arthritis/Lupus/Scleroderma ☐ Other:______________________________
Medication: ☐ Acutane / Cordiarone ☐ Other: Allergies:

Adnexa: ☐ Small Lid Fissure ☐ Deep Set Eyes (☐ PRK Discussed) ☐ Bleph. ☐ Dry Eyes ☐ Incomp. Blinker ☐ Ptosis

| Visual Exam | Right Eye | Left Eye |
|---|---|---|
| **UCVA** | 20/ | 20/ |
| **Manifest Rx** | 20/ | 20/ |
| **Cyclo Rx** | 20/ | 20/ |
| **Keratometry** | | |
| **Cornea** | ☐ Neo: ________+<br>☐ Scarring<br>☐ SPK<br>☐ EBMD<br>☐ Guttata<br>☐ Other | ☐ Neo: ________+<br>☐ Scarring<br>☐ SPK<br>☐ EBMD<br>☐ Guttata<br>☐ Other |
| **AnteriorChamber** | ☐ Normal ☐ Narrow Angle | ☐ Normal ☐ Narrow Angle |
| **Iris** | ☐ Normal Schirmer__________ | ☐ Normal Schirmer__________ |
| **Lens** | ☐ Clear ☐ Opacity: | ☐ Clear ☐ Opacity: |
| **IOP** (applanation) | | |
| **Fundus** (dilated) | ☐ Normal<br>☐ Scleral Buckle C/D ratio:<br>☐ Retinal tear/hole | ☐ Normal<br>☐ Scleral Buckle C/D ratio:<br>☐ Retinal tear/hole |
| **Pachymetry** | | |
| **Plan** | Circle:<br>PRK LASIK Intralase Custom Conv Mono Enh<br>Target Rx: | Circle:<br>PRK LASIK Intralase Custom Conv Mono Enh<br>Target Rx: |

**Comments:**

☐ Risk Benefit Alternative Procedure Reviewed ☐ Discussed Dry Eye ☐ Discussed sig. risk of Glare/halos due to ATR and/or Large pupils. Pt. accepts.
☐ Presbyopia discussed ☐ Monovision discussed ☐ Pt declines monovision and accepts readers ☐ Pt accepts monovision and its limitations and benefits.
☐ **Informed consent discussed and signed** ☐ **Comanagement consent signed**

**Surgeon/Doctor Preference:** **Quoted Fee: $ /eye**

Doctor Signature:_____________________________________________Date:___________

Revised 062010