

# 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

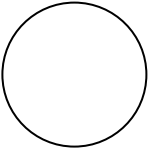
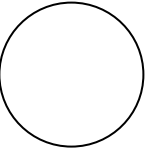
Binocularity:  wnl  \_\_\_\_\_ Eye Dominance:  OD  OS Pupils (bright/dim): \_\_\_\_/\_\_\_\_ OD

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            |  <ul style="list-style-type: none"> <li><input type="checkbox"/> Neo: _____+</li> <li><input type="checkbox"/> Scarring</li> <li><input type="checkbox"/> SPK</li> <li><input type="checkbox"/> EBMD</li> <li><input type="checkbox"/> Guttata</li> <li><input type="checkbox"/> Other</li> </ul> |  <ul style="list-style-type: none"> <li><input type="checkbox"/> Neo: _____+</li> <li><input type="checkbox"/> Scarring</li> <li><input type="checkbox"/> SPK</li> <li><input type="checkbox"/> EBMD</li> <li><input type="checkbox"/> Guttata</li> <li><input type="checkbox"/> Other</li> </ul> |
| Anterior Chamber  | <input type="checkbox"/> Normal <input type="checkbox"/> Narrow Angle  | <input type="checkbox"/> Normal <input type="checkbox"/> Narrow Angle   |
| Iris              | <input type="checkbox"/> Normal Schirmer _____   | <input type="checkbox"/> Normal Schirmer _____  |
| Lens              | <input type="checkbox"/> Clear <input type="checkbox"/> Opacity:   | <input type="checkbox"/> Clear <input type="checkbox"/> Opacity:  |
| IOP (applanation) |  |   |
| Fundus (dilated)  | <input type="checkbox"/> Normal<br><input type="checkbox"/> Scleral Buckle C/D ratio:<br><input type="checkbox"/> Retinal tear/hole  | <input type="checkbox"/> Normal<br><input type="checkbox"/> Scleral Buckle C/D ratio:<br><input type="checkbox"/> Retinal tear/hole   |
| Pachymetry        |  |   |
| Plan              | Circle:<br>PRK LASIK Intralase Custom Conv Mono Enh<br><br>Target Rx:  | Circle:<br>PRK LASIK Intralase Custom Conv Mono Enh<br><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: \_\_\_\_\_