

DOCTOR INFORMATION

Name _____
Email _____
Phone _____
Fax _____



BARRIE
LASIK CENTRE

Toll Free: 877-230-2020
Phone: 705-797-1700
Fax: 705-797-1800

PATIENT INFORMATION

Patient Name _____ Date of Birth ____/____/____ Gender M F
Phone _____ H W
Address _____ Email _____

REFERRAL FOR : CUSTOM ALL LASER LASIK / PRK / CATARACT / RLE / ICL
EYE HISTORY

Any History of Contact Lens Use: Y / N SCL : RGP / PMMA Successful Wearer? Y N
Last worn _____ If No, why? _____
Reading Correction with CL + _____ MONO: Y N OD / OS TARGET : _____

EYE HEALTH none of the below (or circle all that apply)

Trauma / Glaucoma / Retinal or Optic Nerve Disease / HSV or HZO / Cataracts / Strabismus
Amblyopia / Keratoconus or FH / Prior Refractive Surgery / Any Eye Surgery

GENERAL HEALTH

Allergies _____ Latex Allergy Y N Anaesthetic Difficulties Y N
Medications _____ Pacemaker Y N Pregnant or Nursing Y N

HEALTH CONDITIONS none of the below (or circle all that apply)

Uncontrolled Diabetes / Rheumatoid Arthritis / Psoriatic Arthritis / Lupus / Fibromyalgia / Crohn's / MS
Ankylosing Spondylitis / Cancer / Scleroderma / AIDS / Other Immune Compromised Conditions / Other _____

REFRACTION

Dry : OD _____ 20/ OS _____ 20/ ADD _____
Wet: OD _____ 20/ OS _____ 20/ UCVA _____

Stability: Has there been more than 0.50 D change in past year? Y N

Dominant Eye: OD OS

CLINICAL EXAMINATION

Slit Lamp Exam OD OS
Lids / Lashes: Clear / Blepharitis (circled) Lids / Lashes: Clear / Blepharitis (circled)
Conj: White / Injected (circled) Conj: White / Injected (circled)
Cornea: Clear (circled) Cornea: Clear (circled)
Neo: ____/4 + (circled) Neo: ____/4 + (circled)
Y N Dry Eye (TBUT): _____ Y N Dry Eye (TBUT): _____

Fundus Exam OD OS
Lens: _____
Disc: _____
Macula: _____
Periphery: _____
IOP: _____
Pupil (dim) _____ mm _____ mm

Comments _____

Signature _____ Date _____