SightLine Laser Eye Center

PRE-PROCEDURE EVALUATION

Please fax this form as soon as possible to 724-933-6051.

REFERRING DOCTOR _____ EXAM DATE _____

PATIENT NAME _____ PROCEDURE DATE _____

ADDRESS _____ SEX: □ M □ F D.O.B. _____

CITY_____ STATE_____ ZIP_____ HOME PHONE _____

OCCUPATION: _____ CELL/WORK PHONE _____

PROCEDURE TYPE OD: □ LASIK □ PRK

OS: □ LASIK □ PRK

PAYMENT & FINANCE I HAVE DISCUSSED FEES WITH THE PATIENT: $ _____ PER EYE.

($1800.00/eye Center Fee + $_____/eye Case-Management Fee)

PAYMENT COLLECTION (please choose one):

- □ OUR OFFICE will collect FULL PAYMENT from the patient & forward the center fee to SightLine.
- □ SIGHTLINE should collect FULL PAYMENT on the day of surgery & forward the case-mgt fee to our office.
- □ SIGHTLINE should collect ONLY THE CENTER FEE. (Our office will collect the case-mgt fee.)
- □ The patient will be FINANCING $ _____ through Care Credit. (If the amount financed is less than the total fee to the patient, the balance will be collected by: □ Our office □ SightLine.)

Does the patient have any **ALLERGIES TO MEDICATIONS** including analgesics, that may be used in this procedure?
□ Yes □ No If yes, list

Are there any **HEALTH CONDITIONS** or **CURRENT MEDICATIONS** which may adversely impact this patient's outcome or long term ocular health? □ Yes □ No
If yes, list and explain:

Are there any past or present **OCULAR CONDITIONS**, revealed by dilated exam or history, which may adversely impact this patient's outcome or long term ocular health? □ Yes □ No
If yes, list and explain:

BASEMENT MEMBRANE DYSTROPHY? □ Yes □ No

DRY EYE CONDITION? □ Yes □ No If yes, explain:

PATIENT NAME: _____

RECENT CONTACT LENS WEAR? □ Yes □ No Type _____

REFRACTIVE STABILITY ACHIEVED? □ Yes □ No

UNCORRECTED VISUAL ACUITY		**BEST CORRECTED**	**IOP**
OD 20/ _____	□ Less Than 20/400	OD 20/ _____	OD _____
OS 20/ _____	□ Less Than 20/400	OS 20/ _____	OS _____

KERATOMETRY OD_____ @ _____ deg. by _____ @ _____ deg.

OS_____ @ _____ deg. by _____ @ _____ deg.

Having evaluated both the cycloplegic and manifest refractions, the **BASE TREATMENT PRESCRIPTION** to use is:

OD Sphere _____ Cyl. _____ Axis _____

OS Sphere _____ Cyl. _____ Axis _____

Desired **OUTCOME** (This will be added to or subtracted from the above prescription to achieve the desired outcome.)

OD: □ Emmetropia □ Myopia If so, what power? _____

OS □ Emmetropia □ Myopia If so, what power? _____

OPTIONAL TESTING	**TOPOGRAPHY** Enclosed □ Yes □ No	**PACHYMETRY**	**PUPIL SIZE** By Scotopic Pupilometer □ Yes □ No DIM LIGHT	NORMAL LIGHT
		OD _____	OD_____mm	OD_____mm
		OS _____	OS_____mm	OS_____mm

□ Yes □ No **CONSENT FORM** risks and expectations reviewed & a copy was given to the patient.

□ Yes □ No I plan to be **AT THE CENTER** with my patient.

□ Yes □ No **I PLAN TO CONTACT MY PATIENT** the evening of the procedure.

□ Yes □ No I would like the Center **STAFF TO CONTACT MY PATIENT** the evening of the procedure.

□ Yes □ No Patient given **PRE-PROCEDURE INSTRUCTIONS** and **DIRECTIONS** to Center.

□ Yes □ No Patient scheduled for **1-DAY POST-OP APPOINTMENT** at our office.

COMMENTS:

_____ Report Faxed to SightLine

Signature _____