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 _____ SEX: □ M □ F D.O.B. _____

PREFERRED PHONE _____ PROCEDURE DATE (if scheduled) _____

PREFERRED PROCEDURE TYPE □ LASIK □ PRK

PAYMENT & FINANCE I HAVE DISCUSSED FEES WITH THE PATIENT: $ _____ PER EYE.
($1975.00/eye Center Fee + $_____/eye Case-Management Fee)

PAYMENT COLLECTION (please choose one): □ Sightline □ Our Office □ Each collects own fee

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Does the patient have any **ALLERGIES TO MEDICATIONS** including analgesics, **HEALTH CONDITIONS (including pregnancy or nursing), CURRENT MEDICATIONS (including Accutane and Cordarone), PAST OR PRESENT OCULAR CONDITIONS (including Keratoconus for patient or immediate family member)** that may adversely impact the patient's procedure, outcome or long term ocular health?
□ Yes □ No If yes, list

BASEMENT MEMBRANE DYSTROPHY? □ Yes □ No **DRY EYE CONDITION?** □ Yes □ No If yes, explain:

REFRACTIVE STABILITY ACHIEVED? □ Yes □ No **RECENT CONTACT LENS WEAR?** □ Yes □ No Type:

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 _____ VA _____ **Pachymetry** _____

OS Sphere _____ Cyl. _____ Axis _____ VA _____ _____

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? _____

COMMENTS:

_____ Report Faxed to SightLine Signature _____