SightLine Laser Eye Center

ENHANCEMENT 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 ______________________________

ORIGINAL PROCEDURE DATE __________________

LOCATION: □ SIGHTLINE □ OTHER: ______________________________

PROCEDURE TYPE: OD: □ LASIK □ PRK □ OTHER: ______________________________

OS: □ LASIK □ PRK □ OTHER: ______________________________

ORIGINAL PRESCRIPTION
(prior to initial procedure): OD Sphere ____________________ Cyl. _______________ Axis _______________

OS Sphere ____________________ Cyl. _______________ Axis _______________

REASON FOR ENHANCEMENT:

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 ____________________________