LASER VISION RETREATMENT EVALUATION FORM

Referring Doctors: Please fill out the Patient Refractive / Eye Health information below and/or send a copy of your comprehensive eye exam including:
   1. Cycloplegic Refraction
   2. Dominate Eye
   3. Keratometric Readings

Email results to patientcare@lasikplus.com or fax to 513-792-5637. The medical team at LasikPlus requires all patients seeking a retreatment to obtain a comprehensive eye exam with a cycloplegic refraction to determine if a retreatment is medically appropriate and safe.

PATIENT INFORMATION
Name: Date of Birth: Phone:

REFERRING DOCTOR INFORMATION
Referring Doctor: Practice Name:
Phone: Fax: Email:

PATIENT REFRACTIVE / EYE HEALTH INFORMATION
Date: __________
Best Uncorrected VA: OD: 20/___ OS: 20/___ OU: 20/___

Dry Refraction
OD _____________________________ 20/___
OS _____________________________ 20/___

Cycloplegic Refraction
OD _____________________________ 20/___
OS _____________________________ 20/___
**required

Keratometric Readings
OD: _____________________________
OS: _____________________________
IOP: circle NCT Applanation OD: ______ mmHG
Other: _________ OS: _______ mmHG Time:

Any remarkable SLE Findings:

Any remarkable DFE Findings:

Other:

Please email results to patientcare@lasikplus.com or fax to 513-792-5637