V81420

Office Use Only: Patent ID#_____

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. **Dominant Eye**

Email results to enh@lasikplus.com or fax to 513-792-5637. The medical team at Lasik*Plus* **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: _____

Chief Complaint:

Best **Uncorrected** VA: OD: 20/___ OS: 20/___ OU: 20/___

Dry Refraction OD_____ 20/___
OS _____ 20/___

Wet/Cyclo Refraction: OD_____ 20/___
OS _____ 20/___

Circle Dominant Eye: **R** **L**

Any remarkable SLE Findings:

Any remarkable DFE Findings:

Other:

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