LasikPlus

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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 medicalrecords@LasikPlus.com or fax to 513-672-9749. 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: _____

PATIENT REFRACTIVE / EYE HEALTH INFORMATION **Exam Date: _____**

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

Dry Refraction OD_____ 20/___
OS _____ 20/___

Cycloplegic Refraction: OD_____ 20/___
OS _____ 20/___
*****required***

Any remarkable SLE Findings:

Any remarkable DFE Findings:

Other:

Please email results to medicalrecords@LasikPlus.com or fax to 513-672-9749
or call 1-800-557-1240