LASIK.com

V10.16.24

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LASER VISION RETREATMENT EVALUATION FORM

Email this completed form to ENH@Lasik.com or fax it to 513-792-5637. The medical team at the LASIK.com affiliated surgery center **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. Failure to complete all requested information will result in the form being rejected.

PATIENT INFORMATION

Name: Date of Birth: Phone:

OPTOMETRIST INFORMATION

Optometrist: Practice Name:

Phone: Fax: Email:

PATIENT REFRACTIVE / EYE HEALTH INFORMATION

Date: _____

Chief Complaint:

Uncorrected VA: OD: 20/_____ OS: 20/____ OU: 20/____

Dry Refraction OD_____20/____
OS _____20/____

Wet/Cyclo Refraction: OD_____ 20/____
OS _____20/____

Circle Dominant Eye (circle one): R L

Any remarkable SLE Findings (circle one): Yes No

If yes, please explain:_____

Any remarkable DFE Findings (circle one): Yes No

If yes, please explain:_____

Other:

Please email completed form to enh@lasik.com or fax to 513-792-5637