LASIK.com

V10.16.24

Office Use Only: Patent ID#__________________

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