

DOCTOR INFORMATION

Name _____
 Clinic Name _____
 Email _____
 Phone _____



CLEAR VISION SURGICAL

KITCHENER-WATERLOO

P 226-499-2021 | F 226-499-3021

SURGEON PREFERENCE

DR. ALANGH
DR. MOINUL

DR. DESAI
DR. RODRIGUEZ

DR. GULAMHUSEIN
DR. XU

DR. WILKINSON
FIRST AVAILABLE

PATIENT INFORMATION

Patient Name _____ DOB (MM/DD/YY) _____ Gender **M** **F** **Other**
 Email _____ Phone _____ **H** **W**
 Address _____

Mobility Status Walking Walker/Device Wheelchair - Can Patient Transfer? **Y** **N**

REASON FOR REFERRAL

LASIK **PRK** **CATARACT** **RLE** **ICL** **CXL** **YAG** **OTHER** _____

OCULAR HEALTH & HISTORY

Any History of Contact Lens Use? **Y** **N** Soft Hard Successful Wearer? **Y** **N**
 Last Worn _____ If no, why? _____
 Reading Correction with CL _____ + _____ MONO **Y** **N**
 Prior Refractive Surgery? **Y** **N** If yes, please describe _____ HYPEROPIC MYOPIC
 Ocular History _____

GENERAL HEALTH

Medications _____ Allergies _____
 Pregnant or Nursing Diabetes Hypertension HIV/AIDS Hepatitis Rheumatoid Arthritis Lupus Fibromyalgia
 Other Immune Compromised Conditions Other _____

REFRACTION

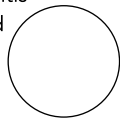
Dry (Current): OD _____ 20 / OS _____ 20 / ADD _____
 Dry (Previous): OD _____ 20 / OS _____ 20 / ADD _____
 Wet: OD _____ 20 / OS _____ 20 /

For Lasik or PRK Referrals - Stability: Has there been more than 0.50 D change in past year? **Y** **N**

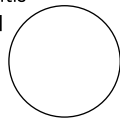
CLINICAL EXAMINATION

Slit Lamp Exam

OD
 Lids / Lashes: Clear Blepharitis
 Conj: White Injected
 Cornea: Clear
 Neo: _____ / 4 +
 Dry Eye (Schirmer, TBUT): _____



OS
 Lids / Lashes: Clear Blepharitis
 Conj: White Injected
 Cornea: Clear
 Neo: _____ / 4 +
 Dry Eye (Schirmer, TBUT): _____



Fundus Exam

Lens: _____
 Disc: _____
 Macula: _____
 Periphery: _____
 IOP: _____

Was this a dilated eye exam? **Y** **N**

Comments _____

Signature _____ Date _____