INSIGHT VISION GROUP

LASIK/PRK/ICLMeasurements

Referring Doctor:______________________________

Phone:______________________________

Please FAX completed form to:
Parker: 720.880.6460
Boulder: 303.593.2199

Patient

First Name:	Last Name:	**Allergies:**	Birthdate:

Pre-Surgery Evaluation

	OD	OS		OD	OS	Date
UCVA	20/	20/	Current Rx	20/_____	20/_____	
BCVA	20/	20/	Manifest	20/_____	20/_____	
Zone Quick			Cycloplegic	20/_____	20/_____	
Pachymetry						
Pupil Size (scotopic)			**DVP:**	**WTW:**	Dilation: Cyclogyl 1% 0.5% Trop. 1% Phen. 2.5% @	
Dominant Eye OD OS	APD Yes No		**Pentacam or Other** **K's** OD X / X OS X / X			

Angles Open Narrow | Contact Lens Wearer? Yes No Type: Date Last Worn: Stable Yes No

Ocular Assessment

	OD	OS		OD	OS		OD	OS
Tear Status	Normal Dry	Normal Dry	**Cornea**	Clear Opac Neo Dyst	Clear Opac Neo Dyst	**IOP**	____mmHg @_____	____mmHg @_____
Lids/ Conj	Normal Blepharitis	Normal Blepharitis				**Lens**	Clear Opacity	Clear Opacity
Disc	0. Rd. Tilted Myopic Conus	0. Rd. Tilted Myopic Conus	**Macula**	WNL Myopic Degen Other	WNL Myopic Degen Other	**Peripheral Retina**	WNL Lattice Holes Tear RD	WNL Lattice Holes Tear RD
Pentacam/ Topography	WNL CL Warpage Pathology	WNL CL Warpage Pathology						

Doctor's Signature and Date

Name:	Date	F/U

Surgery Plan

OD	OS	OU	LASIK	PRK	Primary	Enhance	Monovision: Yes No	
					Ziemer	Allegretto	Near Eye OD OS Mono Amt. _______	