LASER VISION CENTER
NORTHEAST OHIO EYE SURGEONS

Refractive Surgery Consult Request Date: _____

☐ Any doctor
☐ Lawrence Lohman, M.D., FACS
☐ Marc Jones, M.D.. FACS
☐ Elizabeth Muckley, O.D.,FAAO
☐ William Rudy, O.D.,FAAO
☐ Katie Greiner, O.D., M.S.,FAAO
☐ Katherine Hastings, O.D.
☐ Marcella Pipitone, O.D.

4277 Allen Road
Stow, OH 44224

Phone 330-928-0201 *Toll-Free* 800-548-1729 *Fax* 330-926-0201

Patient Name: _____ **DOB:** _____

Home Phone: _____ **Cell :** _____

For referral coordination please call 330-929-8607 and/or fax this information to 330-926-0201. One of our Refractive Surgical Counselors will contact the patient to schedule the appropriate appointment.

Refractive Information:

Current Spec RX:

OD: _____ 20/_____

OS: _____ 20/_____

Add: _____ ☐BIF ☐PAL

Latest manifest Refraction Date: _____

OD: _____ 20/_____

OS: _____ 20/_____

Add: _____

Current Contact lens Rx:

OD: _____ 20/_____

OS: _____ 20/_____

CL Info: _____

CL Info: _____

Cycloplegic Refraction Date: _____

Please use 1% Cyclopentalate—at least 20 minutes prior

OD: _____ 20/_____

OS: _____ 20/_____

Ocular Health:	**OD**	**OS**
	Normal	**Normal**
Adnexa	☐	☐
Conj	☐	☐
Cornea	☐	☐
AC	☐	☐
IOP:	_____/_____ **Ta, Tp, NCT**	
	☐**Dilated**	☐**Undilated**
Lens	☐	☐
Optic Nerve	☐	☐
Cup/Disc:	_____/_____	
Macula	☐	☐
Vasc	☐	☐
Periph Fundus	☐	☐**Intact 360**

The following are NOT absolute contraindications, but should be considered. Please contact Dr. Bill Rudy regarding any refractive surgery concerns.

Binocular Dysfunction	Yes	No
☐Strabismus ☐Amblyopia ☐Prism		
Refractive Change >0.50 x 1y	Yes	No
Pregnant	Yes	No
Autoimmune condition	Yes	No
(RA, Sjogrens, Lupus, Etc)	Yes	No
If yes, Controlled?	Yes	No
Diabetic?	Yes	No
If yes, Controlled?	Yes	No
Corneal disorders	Yes	No
Epith Basemt Memb Dyst	Yes	No
HSV / HZO	Yes	No
Keratoconus / Pellucid	Yes	No
Irregular Astig	Yes	No
Dry Eye		
If yes, ☐Mild ☐Moderate ☐Severe		
Dry eye only associated with CL use	Yes	No
History of Restasis	Yes	No
History of Punctal Plugs	Yes	No
Presbyopia	Yes	No

Multifocal CLs
☐Good ☐Fair ☐Poor ☐Never Attempted

Monovision Trial
☐CL ☐Clinic Demo ☐Pt Declined
☐Good ☐ Fair ☐Poor ☐Never Attempted

Best tolerated near add: _____

Near Eye: ☐OD ☐OS

Please describe any abnormal findings/additional comments:

_____

_____

_____

If Presbyopic, would you recommend Monovision:?

Yes No

Distant eye? _____Near Eye: _____

NEOES will contact the above patient. Additional tests including wave scan, topography, pentacam corneal analysis and pachymetry will need to be completed in order to choose the best procedure and treatment for this patient. We will return the patient to your care once the patient is medically stable.

Dr. Name: _____

Office Phone Number: