Comanaging Doctor Refractive Admittance Report

Patient Information		Date of Exam:
Last Name:	First:	Middle:
Mailing Address		
City:	State:	Zip Code:
Home Telephone: ( )		Date of Birth:
Special Note:		

Referring Doctor Information		
Last Name:	First:	Middle:
Office Mailing Address		
City:	State:	Zip Code:
Office Telephone: ( )	UPIN #:	
Doctor's Signature:		

Name of Doctor Patient to See:

1 Reasons Why Patient Desires Refractive Surgery:

Can the patient wear contact lenses? ☐ Yes ☐ No (If no, what problems?):

Type of contact lens (if applicable): ☐ Rigid ☐ Soft	Base Curve: Power: Diameter:
How long has the patient worn contact lenses?:	Ocular Dominance: ☐ OD ☐ OS

2	Uncorrected Va Distance	OD:	OS:	
3	Corrected Va Distance	OD:	OS:	
4	External Exam	EOM's OD:	OS:	
	Pupil Reaction OD: OS:	Pupil Diameter OD: OS:	IOP Pressure OD: OS:	
5	Slit Lamp Exam SLE)	OD:	OS:	
6	Dry Eye Test (Schirmer, Zone-Quick)	OD:	OS:	
7	VF Confrontation	OD:	OS:	
8	Refraction OD:	for VA:	OS:	for VA:
9	Cycloplegic Rfn w/ Cyclopentolate 1%	OD:	OS:	
10	Fundus with B.I.O.	OD:	OS:	
11	Keratometric Reading OD:		OS:	
12	Comment			

Patient to Discontinue Contact Lens Wear Prior to Appointment Soft 14 Days, Gas-Permeable 21 Days
Patient Should Bring This Form to Carolina Eye Associates - Do Not Mail
Fax completed form to (910) 295-2984.

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