



LASER VISION  
L O N D O N

# LASER VISION CORRECTION (LASIK/PRK) REFERRAL FORM

1695 Wonderland Road North London ON  
P 519-204-7777 | F 519-204-1010 | 1-877-417-2020  
info@laservision-london.com | laservision-london.com

## REFERRING DOCTOR INFORMATION

Doctor Name \_\_\_\_\_ Billing # \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

D.O.B. \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work # \_\_\_\_\_

Address \_\_\_\_\_

Currently Driving? Y N CTL User? Y N Monovision: Y N If Monovision: Right Left

CTL Use: SCL X.W. SCL Toric SCL RGP Multifocal Rx Stable x12 Months (<0.5D change): Y N

Dominant Eye: Right Left Years of CTL Use: \_\_\_\_\_ CTL Problems? Y N \_\_\_\_\_

Last worn: \_\_\_\_\_ Pregnant/Nursing? Y N

## PATIENT EVALUATION

OD: UCVA 20 / \_\_\_\_\_ BCVA 20 / \_\_\_\_\_ Pachymetry: \_\_\_\_\_ μm IOP \_\_\_\_\_ K readings: \_\_\_\_\_ / \_\_\_\_\_ @ \_\_\_\_\_

OS: UCVA 20 / \_\_\_\_\_ BCVA 20 / \_\_\_\_\_ Pachymetry: \_\_\_\_\_ μm IOP \_\_\_\_\_ K readings: \_\_\_\_\_ / \_\_\_\_\_ @ \_\_\_\_\_

Manifest Refraction: OD \_\_\_\_\_ OS \_\_\_\_\_

Cycloplegic Refraction: OD \_\_\_\_\_ OS \_\_\_\_\_

Current Prescription: OD \_\_\_\_\_ OS \_\_\_\_\_

Cornea/Lid: OD: Normal Findings: \_\_\_\_\_ OS: Normal Findings: \_\_\_\_\_

Lens: OD: Clear Findings: \_\_\_\_\_ OS: Clear Findings: \_\_\_\_\_

Retina/Macula: OD: Normal Findings: \_\_\_\_\_ OS: Normal Findings: \_\_\_\_\_

Previous Eye History (conditions, diagnosis, trauma, surgeries): \_\_\_\_\_ None, or specify: \_\_\_\_\_

General Health: Good Uncontrolled Diabetes Rheumatoid Arthritis Psoriatic Arthritis Lupus Fibromyalgia

Crohn's MS Ankylosing Spondylitis Cancer Scleroderma AIDS

Other Immunological Conditions Other: \_\_\_\_\_