



**EYE Q Premium Laser**

Co-Management Pre-Operative Refractive Assessment: Page 1

Date: \_\_\_\_\_

Co-Managing Dr. Name: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Patient First Name: \_\_\_\_\_ Patient Last Name: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ AB Health Care #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Family Hx of eye disease: \_\_\_\_\_ Keratoconus: \_\_\_\_\_

Ocular Hx: \_\_\_\_\_

Contact lens Hx: \_\_\_\_\_ How many years: \_\_\_\_\_ When last worn: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

General Health: \_\_\_\_\_

Diabetes: Y / N Hypertension: Y / N Migraines: Y / N Accutane: Y / N Immune disorder: Y / N

Pregnant/ Nursing: Y / N Keloid Scarring: Y / N HIV: Y / N Hepatitis: Y / N Rheumatoid Arthritis: Y / N

**OD**

Glasses Rx: \_\_\_\_\_ VA: 20/\_\_\_\_\_

Age of Glasses: \_\_\_\_\_

Manifest Rx: \_\_\_\_\_ VA: 20/\_\_\_\_\_

Cyclo Rx: \_\_\_\_\_ VA: 20/\_\_\_\_\_

K1: \_\_\_\_\_ K2: \_\_\_\_\_

IOP: \_\_\_\_\_ Time: \_\_\_\_\_

Pupils: \_\_\_\_\_mm in dim light      Norm / Abn

Cornea: \_\_\_\_\_ Lens: \_\_\_\_\_

Optic Disc: \_\_\_\_\_ C/D: \_\_\_\_\_

Retina/ Periphery: \_\_\_\_\_

Dilation with Cyclogel Y / N      Pachymetry: \_\_\_\_\_

Dr. Comments:  
\_\_\_\_\_  
\_\_\_\_\_

**OS**

Glasses Rx: \_\_\_\_\_ VA: 20/\_\_\_\_\_

Age of Glasses: \_\_\_\_\_

Manifest Rx: \_\_\_\_\_ VA: 20/\_\_\_\_\_

Cyclo Rx: \_\_\_\_\_ VA: 20/\_\_\_\_\_

K1: \_\_\_\_\_ K2: \_\_\_\_\_

IOP: \_\_\_\_\_ Time: \_\_\_\_\_

Pupils: \_\_\_\_\_mm in dim light      Norm / Abn

Cornea: \_\_\_\_\_ Lens: \_\_\_\_\_

Optic Disc: \_\_\_\_\_ C/D: \_\_\_\_\_

Retina/ Periphery: \_\_\_\_\_

Dilation with Cyclogel Y / N      Pachymetry: \_\_\_\_\_

Dr. Comments:  
\_\_\_\_\_  
\_\_\_\_\_



**EYE Q Premium Laser**

**When discussing Custom Femto Lasik with your patient:**

- Please advise the patient of risks and benefits regarding refractive laser eye surgery.
- Advise the patient that **soft** contact lenses should not be worn for at least 7 days prior to surgery.
- Advise the patient that **hard** contact lenses should not be worn for at least 4 weeks prior to surgery and an additional week per decade worn.
- Advise the patient to refrain from using face cream, make-up or cologne on the day of surgery. No eye make-up 2 days prior to surgery.
- Advise the patient to please bring a driver on day of surgery.
- Advise the patient to avoid extreme dusty/smoky areas for 2 weeks post-operative of surgery.
- Advise the patient to abstain from hot tubs or swimming for 4 weeks post-operative of surgery.
- Advise the patient of post-operative exam schedule (i.e. 1 day, 5 days, 1 month, 3 month and 6 months post-operatively)
- Advise the patient that Eye Q Premium Laser is currently using Intralase iFS and latest Schwind Amaris 750s to offer them Custom Femto Lasik Intralase surgery.

**Eye Q Premium Laser will:**

- Inform the patient of their statistics regarding 20/40 and 20/20 vision.
- Inform the patient of post-operative drop schedule, and post-operative visits.
- Inform the patient in detail which surgical procedure is best suited for their eyes.
- Inform the patient of all financial information and details regarding payment options for surgery.

**I confirm that I have reviewed the above listed information with the patient named in this pre-operative refractive assessment. The patient understands that this information will be shared with Eye Q Premium Laser.**

\_\_\_\_\_  
**Optometrist Signature**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**

Pre-Op Assessment Charged by OD: \$\_\_\_\_\_ **EYE Q will deduct up to \$120 from total cost of patient's surgery.**

Thank you for your expertise in completing the CO-MANAGEMENT PRE-OPERATIVE REFRACTIVE ASSESSMENT.