NEBRASKA LASER EYE™
ASSOCIATES
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Nurse on call: (402) 657-6489

LASIK REFERRAL

Referring Dr. _____
Referring doctor location:_____
Patient: _____
Pt's address: _____
City: _____ State _____

Exam date: ____/____/____
Surgery date____/____/____
Pt's DOB:___/____/___ Sex: M F
Phone (___)_____

This patient is currently interested in a LASIK evaluation and possible surgery.

Examination

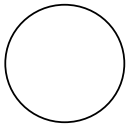
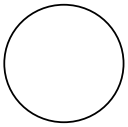
Uncorrected visual acuity OD 20/____ OS 20/____
Dominant eye R / L
Monovision Y / N

Manifest Refraction (12mm vertex) OD _____ 20/_____ OS _____ 20/_____

Cycloplegic Refraction (12mm vertex) OD _____ 20/_____ OS _____ 20/_____

IOP OD _____ mmHg OS _____ mmHg

Topography / Keratometry OD _____ OS _____

OD		(Circle appropriate condition)	**OS**	
clear	blepharitis	**Lids / Lashes**	clear	blepharitis
clear	injected	**Conjunctiva**	clear	injected
deep and clear	cells	**Anterior Chamber**	deep and clear	cells
		Cornea		
				
clear		**Lens**	clear	
0.____		**Disk**	0.____	
normal		**Macula**	normal	
normal		**Vessels**	normal	
normal		**Periphery**	normal	

Patient has been prescribed / given **Vigamox/Maxidex** **Zymaxid/Pred Forte**
to begin qid the day before surgery and for use after surgery.

Preferred procedure Traditional LASIK

This patient would like to be co-managed with our office following LASIK. ½ **Yes** ½ **No**