lumea

☐ Cataract ☐ ICL ☐ RLE ☐ SMILE
☐ LASIK ☐ PRK ☐ Presbyond ☐ Other _____

# Refractive Referral Form

## Patient Information

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Email: _____

HC: _____ VC: _____

## Referring Doctor Information

Name: _____ Billing #: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Email: _____

Fax: _____

Medical Hx/Allergies: _____

Medications: _____

CL Wearer: Y ☐ N ☐ Type: Soft ☐ Hard ☐ RGP ☐ Other: _____

Visit Date: _____

Current Rx: _____ _____ x _____ 20/_____

UCVA distance 20/ _____ UCVA near 20/ _____

Manifest Rx: _____ _____ x _____ 20/_____

Cyclo Rx: _____ _____ x _____ 20/_____

CCT: _____ um

Slit lamp: Fundus:

IOP: _____ mmHg

Current Rx: _____ _____ x _____ 20/_____

UCVA distance 20/ _____ UCVA near 20/ _____

Manifest Rx: _____ _____ x _____ 20/_____

Cyclo Rx: _____ _____ x _____ 20/_____

CCT: _____ um

Slit lamp: Fundus:

IOP: _____ mmHg

Doctor's Comments: _____

See things differently.

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