DOCTOR INFORMATION

Name _____

Email _____

Phone _____

Fax _____

BARRIE LASIK CENTRE
Toll Free: 877-230-2020
Phone: 705-797-1700
Fax: 705-797-1800

PATIENT INFORMATION

Patient Name _____ Date of Birth ____/____/____ Gender M F

Phone _____ H W

Address _____ Email _____

REFERRAL FOR : CUSTOM ALL LASER LASIK / PRK / CATARACT / RLE / ICL

EYE HISTORY

Any History of Contact Lens Use: Y / N SCL : RGP / PMMA Successful Wearer? Y N

Last worn _____ If No, why? _____

Reading Correction with CL + _____ MONO: Y N OD / OS TARGET : _____

EYE HEALTH none of the below ◯ (or circle all that apply)

Trauma / Glaucoma / Retinal or Optic Nerve Disease / HSV or HZO / Cataracts / Strabismus

Amblyopia / Keratoconus or FH / Prior Refractive Surgery / Any Eye Surgery

GENERAL HEALTH

Allergies _____ Latex Allergy Y N Anaesthetic Difficulties Y N

Medications _____ Pacemaker Y N Pregnant or Nursing Y N

HEALTH CONDITIONS none of the below ◯ (or circle all that apply)

Uncontrolled Diabetes / Rheumatoid Arthritis / Psoriatic Arthritis / Lupus / Fibromyalgia / Crohn's / MS

Ankylosing Spondilitis / Cancer / Scleroderma / AIDS / Other Immune Compromised Conditions / Other _____

REFRACTION

Dry : OD _____ 20/ OS _____ 20/ ADD _____

Wet: OD _____ 20/ OS _____ 20/ UCVA OD:____OS:____OU:____

Stability: Has there been more than 0.50 D change in past year? Y N

Dominant Eye: OD OS

CLINICAL EXAMINATION

Slit Lamp Exam	OD	OS
Lids / Lashes:	Clear / Blepharitis	Clear / Blepharitis
Conj:	White / Injected	White / Injected
Cornea:	Clear	Clear
Neo:	_____/4 +	_____/4 +
Y N	Dry Eye (TBUT):_____	Y N Dry Eye (TBUT):_____

Fundus Exam	OD	OS
Lens:	_____	_____
Disc:	_____	_____
Macula:	_____	_____
Periphery:	_____	_____
IOP:	_____	_____
Pupil (dim)	_____ mm	_____ mm

Comments _____

Signature _____ Date _____