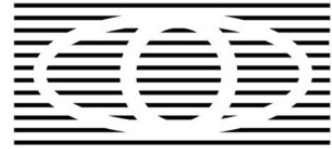


# Refractive Surgery Referral



**TURNER EYE INSTITUTE**

MEDICAL GROUP, INC.

800-339-2733

www.turnereye.com

San Leandro San Francisco San Jose Concord

FAX: 510-357-6330

Referring Dr. \_\_\_\_\_

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Phone \_\_\_\_\_

DOB \_\_\_\_\_

Patient Desires the following surgery: \_\_\_\_\_

Comments: \_\_\_\_\_

<b>Assessment</b>		
Ocular History: (e.g., Injury, Amblyopia, Previous Surgery, etc.) _____		
Medical History: (e.g. Diabetes, Hypertension, Asthma, Lung, Heart, etc.) _____		
Medications: Ocular _____	Systemic: _____	
Allergies: _____	Eye Color: _____	Race: _____
	OD	OS
Present Correction: Glasses/Contacts	_____	_____
Contact Lenses: (circle one)	VA _____	VA _____
Hard/Soft/Daily Wear/Extended Wear		
Manifest Refraction:	_____ VA _____	_____ VA _____
Cyclopegic Refraction: (MYD 1% x2)	_____	_____
(5 min. apart)		
Keratometry Readings: Auto/Manual	_____ @ _____ @ _____	_____ @ _____ @ _____
Intraocular Pressure: AT or NCT	_____ mm Hg	_____ mmHg
Pupil Size (diameter in room and dim illumination)	_____ mm _____ mm Room Dim	_____ mm _____ mm Room Dim
Ocular Motility	Normal/Other _____	Normal/Other _____
Anterior Segment and Fundus	Normal/Other _____	Normal/Other _____
Please circle one answer for each of the following:		
● Monovision: Yes No	● Dominant Eye: R L	
● Patient Needs Pre-Op Consultation: Yes No	● 1 Day Post-Op to be done by: ME Surgeon	
Summary: _____		

Please fax to Turner Eye Institute at  
(510) 357-6330

Signed: \_\_\_\_\_

Assessing Doctor