ALASKA LASIK & CATARACT
THE BEST IN SIGHT CENTER

Fax to 907-569-1564 or mail to:
Alaska Lasik and Cataract Center
235 E. 8th Ave., Suite 3A
Anchorage, AK 99501

Refractive Surgery Referral

Referring Doctor
Name_____
Address_____
Phone (__)_____
Date of Exam _____

Patient Information
Name_____
Address_____
Date of Birth_____
Phone: Hm (__)_____ Wk (__)_____

Surgery Desired: □ iLASIK □ PRK
What refractive error outcome do you recommend for each eye? OD_____ OS_____
If monovision correction is indicated, has patient undergone a contact lens trial? □ Yes □ No
Reasons for interest in surgery:_____
Occupation_____ Hobbies_____

Subjective
Ocular history (i.e., injury, amblyopia, pervious surgery, other)_____
Medical history (i.e., diabetes, heart, lung, arthritis, lupus, pregnant, nursing, other)_____
Medications: Ocular_____ Systemic_____
Allergies □ NKDA □ Other_____

Objective
Corneal Stability: □Soft lens wearer □RGP wearer □Contacts out__week(s) before my cycloplegic refraction.
Important Note: For accurate surgery, soft lenses must be left out at least 7 days prior and RGPs at least 3 weeks prior, or until corneal stability is confirmed.

Dominant eye: □OD □OS	OD	OS
Pupil size (diameter in dim light)	_____mm APD + / - (circle)	_____mm APD + / - (circle)
VA without correction	_____-_____x_____ 20/___	_____-_____x_____ 20/___
Present Rx: □CL □Glasses (add_____)	_____-_____x_____ 20/___	_____-_____x_____ 20/___
Manifest Refraction	_____-_____x_____ 20/___	_____-_____x_____ 20/___
Cycloplegic refraction(w/cyclogyl 1%)	_____-_____x_____ 20/___	_____-_____x_____ 20/___
K-Readings: □Manual □Auto	_____//_____x_____	_____//_____x_____
IOP: □Air □Applanation	_____mm Hg	_____mm Hg
Central corneal thickness	_____microns	_____microns
Ocular motility □ Normal **Or**	_____	_____

Check if normal:	OD	OS		OD	OS
	□	□	Adnexa	□	□ Lens
	□	□	Lids/lashes	□	□ Vitreous
	□	□	Conjunctiva	□	□ Disc
	□	□	Cornea	□	□ Vessels
	□	□	AC	□	□ Macula
	□	□	Iris	□	□ Periphery

Anterior segment abnormal findings
_____
_____
Posterior segment abnormal findings
_____
_____

Assessment
□ Patient appears qualified for iLASIK or PRK as requested.
□ Any abnormal findings are not disqualifying in my opinion.
□ Other_____

Plan
□ I have evaluated this patient and reviewed the risks and benefits of surgery. If deemed suitable, they wish to proceed.

Billing
□ I will bill for follow-up services I provide.
□ Patient will pay ALCC with cash, credit or financing. Please collect $_____ for my Pre and Post-operative services.
(I understand there will be a finance charge to my fees if the patient pays with credit or financing.)