Eye Surgeons of Indiana

Refractive Surgery Referral Form

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **Referral Date:** _____

Referring Doctor: _____

Practice Location: _____

☐ **Appointment Made**
Date: _____

☐ **Please Call Patient To Schedule Appointment**

Recommendation:

☐ LASIK
☐ PRK
☐ EVO Visian ICL (high myopia, thinner corneas)
☐ RLE (hyperopia/presbyopia)

Refractive Target:

OD ☐ Distance ☐ Near
OS ☐ Distance ☐ Near

Contact Lens History:

☐ None ☐ SCL ☐ RGP
☐ Monovision ☐ Distance eye: ☐ OD ☐ OS
☐ Multifocal
**Please d/c at least 1 week prior to consultation, 3 weeks for RGPs*

Current Clinical Findings:

Significant Ocular/Systemic Conditions: ☐ None ☐ Other _____

Pertinent Slit Lamp/Fundus Findings: ☐ None ☐ Other _____

	OD	**OS**
Contact Lens Rx:	_____	_____
Manifest:	_____	_____
Cycloplegic (1% Cyclogyl):	_____	_____
BCVA:	20/_____	20/_____

Comments:

CLEAR FORM

SUBMIT

Please fax this form to our Referral Concierge: Fax: 317.579.7435 / Ph: 317.841.2028