THE WILLIAMSON EYE CENTER

PREOPERATIVE ASSESSMENT/REFERRAL for TREATMENT

Date: ____________________ DOB: ____________________

Patient Name: ____________________ Age: ______ M F

Address: ____________________ Home # ____________________

____________________ Work # ____________________

Vision History ____________________

To Be Filled Out by Referring Optometrist

AutoRefraction **Current RX (Glasses)**

OD ____________________ **OD** ____________________

OS ____________________ **OS** ____________________

UCVA OD 20/____ OS 20/____ Dominant Eye OD OS

BCVA OD 20/____ OS 20/____ Pupil Size OD________mm OS________mm

IOP OD ______ OS ______

OPTOMETRIST RECOMMENDATIONS: iLASIK / PRK / MONOVISION/ CRYSTALENS/ OTHER

____

Appt. Scheduled: WEC ____________________ ____________________

TIME: ____________________ **Co-Managing Physician**

To Be Completed by WEC LASIK Counselor

- ❑ Gas Perm/HARD LENS OFF 3 WEEKS PRIOR TO WU/SX
- ❑ Ext Wear/Toric SOFT LENS OFF 7 DAYS PRIOR TO WU/ SX
- ❑ Daily Wear SOFT LENS OFF 7 DAYS PRIOR TO WU/SX
- ❑ NECESSITY FOR READING GLASSES EXPLAINED TO PATIENT
- ❑ NO MAKE UP, PERFUME, COLOGNE, AFTERSHAVE, ETC. IS TO BE WORN THE DAY OF SURGERY

Workup scheduled ____________________ iLASIK Scheduled ____________________

Counselor ____________________/OD OFFICE Notified Date____________