GULFCOAST EYE CARE

Referral Form

CO-MANAGING DOCTOR

Doctor's Name: _____

Street : _____ Suite: _____

City : _____

State/Province/Zip/Postal Code : _____

Email: _____

Contact Person: _____

Office Phone: _____

Office Fax: _____

Emergency Phone: _____

Preferred Contact: D Office Phone D Fax D Mail D Email

PATIENT INFORMATION

Name (Last): _____ First: _____ M.I. _____

Address : _____ Home Phone: _____

_____ Work Phone: _____

Date of Birth: ____/____/____ Age: _____ D Male D Female E Mail : _____

Month Day Year

Patient Scheduled at GCEC Center for the following; D Surgery D Consult / Testing D Enhancement Date: _____

REFRACTIVE INFORMATION

WEARING: OD: _____ 20/ OS: _____ 20/ Date:

DRY: OD: _____ 20/ OS : _____ 20/ Date:

CYCLO: OD: _____ 20/ OS : _____ 20/ Date:

ADD: +_____ D. K's OD: _____/_____@_____ OS: _____/_____@_____

DOMINANT EYE: D OD D OS RX Stable X 12 Months (< 0.50 D Change) ? D Yes D No Full Cycloplegic for Wet RX? D Yes D No

Contact Lens Use: D D.W. SCL D X.W. SCL D Toric SCL D RGP / PMMA Power: OD:_____OS:_____Contacts Removed On (Date): _____

GCEC recommends patients remove their CL's 7 days prior to their procedure for corneal stability. Corneal stability after CL removal will be dependent on CL fit and materials and will be measured using corneal topography and other mapping tests. GCEC recommends you check with Gulfcoast Eye Care for specific CL removal requirements.

Dilation: D YES D NO Pupils (Dim Illumination) in mm: OD:_____OS:_____Binocular Testing: Normal / Other: Confront. VF: Normal / Attached VF's

ANTERIOR AND POSTERIOR OCULAR EXAMINATION

OD:

Anterior Segment:

Lids Lashes: Clear Blepharitis
Conj: White Injected
Cornea: Clear
Neo:_____/ 4 +
Dry Eye (Schirmer, TBUT) :

Anterior Chamber:

Quiet & Deep Shallow
Clear Inflammation
Lenticular Opacities:
IOP:_____mm @:

DISC:
D Normal
D Pale
D Scleral Crescent
C / D Ratio:

Macular Reflex:
D Excellent
D Good
D Poor

Peripheral Retina:
D Normal
D Thinning
D Lattice / Pavingstone
D Tear/Detachment

OS:

Anterior Segment:

Lids/Lashes: Clear Blepharitis
Conj: White Injected
Cornea: Clear
Neo:_____/ 4 +
Dry Eye (Schirmer, TBUT) :

Anterior Chamber:

Quiet & Deep Shallow
Clear Inflammation
Lenticular Opacities:
IOP:_____mm @:

DISC:
D Normal
D Pale
D Scleral Crescent
C / D Ratio:

Macular Reflex:
D Excellent
D Good
D Poor

Peripheral Retina:
D Normal
D Thinning
D Lattice / Pavingstone
D Tear / Detachment

Comments or other Medical / Ocular History:

Recommend:

D OU D LASIK D PRK D Custom D Conventional
D OD ONLY D Intralase D RLE D RLE D IOL
D OS ONLY D P,I. D CK D LRI
D Other: _____

D Aim Distance OU D Aim Near OD / OS Mono Target:_____Diopters

Discussed w/ patient: D Risks/Benefits D Reading Post Op D Enhancement

1 Day Post-Operative Care to be Completed by: D GCEC D Comanaging Doctor

Fees Quoted:_____ Payment Plan: D Yes D No

Fees Collected at : D GCEC Center D Comanaging Doctor will Collect Fees

Dr. Signature: **Print:** **Date:**

Fax: (727) 823-8796