Pre-Operative Refractive Assessment

re:vision
Anterior Segment Specialists

Please print legibly and tick as required ☑

Assessment Date _____

Patient Name _____

Address _____

_____

DOB _____

Referring Optometrist _____

Address _____

_____

Phone _____

Phone - Work _____ Home _____ Mobile _____

Email _____

Occupation _____

General medical health ◯ Good Details _____

Regular medication _____

Any allergies? ◯ No ◯ Yes - list details _____

Family history - medical and ocular _____

Past ocular history - medical and surgical _____

Examination

	Right (OD)	Left (OS)
Current spectacle refraction		
Add - if applicable		
If wearing contacts state type		
Is refraction stable	◯ Yes ◯ No	◯ Yes ◯ No
Best corrected visual acuity (BCVA)	6/	6/
Current refraction (include BVD if >6 dioptres		
Visual acuity with current refraction		
Keratometry (dioptres, axis)		
Slit lamp exam ◯ Normal ◯ Any abnormalities		
Intraocular pressure	mmHg	mmHg
Fundoscopy – ◯ Dilated ◯ Non dilated ◯ Any abnormalities		

Why is the patient interested in refractive surgery? _____

Any particular comments as to the patient's suitability for surgery? _____

The patient is referred to ◯ Dr Trever Gray ◯ Dr Mo Ziaei ◯ Any Re:Vision surgeons

Signed _____ Date _____

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