

PRE-OPERATIVE REFRACTIVE ASSESSMENT



Please Print legibly and tick as required.

Patient's name _____ Referring Optometrist _____
 Address _____ Address _____

 DOB _____ Phone _____
 Phone (h) _____ (w) _____ (mobile) _____
 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Current refraction (incl. BVD if >6 dioptres)		
Visual acuity with current refraction	6/	6/
Keratometry (dioptres, axis)		
Slit lamp exam <input type="checkbox"/> Normal Any Abnormalities		
Intraocular pressure	mmHg	mmHg
Fundoscopy - <input type="checkbox"/> Dilated <input type="checkbox"/> Non dilated Any Abnormalities		

Why is the patient interested in refractive surgery? _____

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

This patient is referred to Dr Gray Dr Mantell Dr Morris Dr Ring Dr Watson
 any of Eye Institute's refractive surgeons

Signed _____ Date _____

Eye Institute - 125 Remuera Rd - Auckland 1050 Telephone 0800 99 20 20 Fax 09 522 5770
 Please charge your normal fee direct to the patient