Pre-Operative Exam

Referring patient for the following: (circle one)
Refractive Evaluation / Cataract Evaluation / Keratoconus Evaluation

Patient Information

name

dob (mm/dd/year) phone

date of this exam

date of procedure

Referring Information

practice name

referring doctor

office phone/fax

office contact

Clinical Findings: ____________ ____________ ____________

date of exam date CL last worn CL type/brand

	OD		OS	
UCVA		20/_______		20/_______
Manifest Refraction	______________________	20/_______	______________________	20/_______
Cycloplegic Refraction	______________________	20/_______	______________________	20/_______
Present Glasses	______________________	20/_______	______________________	20/_______

________ ________
date of RX add

Keratometry
Manual / Topo / Auto ____________ / ____________ @ __________ ____________ / ____________ @ __________

IOP @ ________am/pm _______ mmHG Aim: Dist / Mono __________ _______ mmHG Aim: Dist / Mono __________

Check if Normal	OD	OS		OD	OS		
	☐	☐	Adnexa	☐	☐	Lens	Anterior segment *abnormal* findings
	☐	☐	Lids/Lashes	☐	☐	Vitreous	
	☐	☐	Conjunctiva	☐	☐	Vessels	Posterior segment *abnormal* findings
	☐	☐	Cornea	☐	☐	Macula	
	☐	☐	AC	☐	☐	Periphery	
	☐	☐	Iris	CD OD _______OS _______			

Assessment & Plan

doctor signature date

Please fax completed Pre-Op Exam to nJoy Vision at 405.842.6130.