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 | **DOM EYE** **OD / OS**

UCVA	**OD** 20/_____	**OS** 20/_____
Manual 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	
☐	☐	Cornea	☐	☐	Macula	Posterior segment *abnormal* findings
☐	☐	AC	☐	☐	Periphery	
☐	☐	Iris	CD OD _____ OS _____			

Assessment & Plan

_____ doctor signature

_____ date

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