GIMBEL EYE CENTRE®

Refractive Surgery Assessment & Referral

PLEASE PRINT or TYPE Assessment Date (m/d/y): _____

Patient Name (Dr./Mr./Mrs./Ms./Miss): _____ Sex: ☐ Female ☐ Male

DOB (m/d/y): _____ Address: _____

City: _____ Prov/State: _____ Postal/Zip: _____

Telephone (res): _____ Telephone (bus): _____ Telephone (cell): _____

Name of Doctor Assessing: _____

Telephone: _____ City: _____

Patient History

Ocular History (e.g., Injury, Amblyopia, Previous Eye Surgery Dry Eye, Motivation for surgery, etc.): _____

Medical History: _____

Please Check: ☐ Diabetes ☐ Vascular Disease ☐ Ocular Herpes Simplex/Zoster ☐ Pregnancy/Nursing
☐ Collagen ☐ Auto Immune ☐ Other (please specify): _____

List Medications, include Imitrex® (migraine), Accutane® (acne), Amiodarone® (cardiac anti-arrhythmic) &/or Flomax® (urinary flow):

Ocular: _____ Systemic: _____

	OD	OS
Current Spectacles Rx		
Prism: ☐ Yes ☐ No	Eye Dominance: ☐ OD ☐ OS	
Current Contact Lens Rx		
If contact lenses are worn, indicate: ☐ Soft ☐ RGP ☐ Monovision Simulated		
Refraction Date:	**OD**	**OS**
Vertex Distance:	20/	20/
Keratometry Readings ☐ Manual ☐ Auto		
Pupil Size (Diameter in dim illumination)	mm	mm
Best Corrected Visual Acuity		
Anterior Segment		
Posterior Segment ☐ Dilated ☐ Undilated		
Crystalline Lens		
C/D (Cup-to-disc ratio)		
Macula		
Periphery		
Pachymetry		

Monovision Discussed ☐ Yes ☐ No Contact Lens Monovision Trial Completed ☐ Yes ☐ No

Comments: _____

_____ Doctor Signature: _____

☐ Gimbel Eye Centre Calgary Fax: (403) 202-3303 ☐ Gimbel Eye Centre Edmonton Fax: (780) 452-4114