DOCTOR INFORMATION

Name _____

Email _____

Phone _____

Fax _____

BURLINGTON LASER EYE CENTRE
3305 Harvester Road, Burlington, ON L9A 4V7
Tel: 888-636-4733 • Fax: 905-632-9778

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Gender ◯ M ◯ F

Email _____ Phone _____ ◯ H ◯ W

Address _____

REFERRAL FOR: ◯ **CUSTOM ALL LASER LASIK** ◯ **PRK** ◯ **CATARACT** ◯ **RLE** ◯ **ICL** ◯ **OTHER**

EYE HISTORY

Any History of Contact Lens Use? ◯ Y ◯ N SCL: ◯ RGP ◯ PMMA Successful Wearer? ◯ Y ◯ N

Last Worn _____ If no, why? _____

Reading Correction with CL + _____ MONO ◯ Y ◯ N

EYE HEALTH None of the below ◯ or select all that apply:

◯ Trauma ◯ Glaucoma ◯ Retinal or Optic Nerve Disease ◯ HSV or HZO ◯ Cataracts ◯ Strabismus

◯ Amblyopia ◯ Keratoconus or FH ◯ Prior Refractive Surgery ◯ Any Eye Surgery

GENERAL HEALTH

Allergies _____ Latex Allergy ◯ Y ◯ N Anaesthetic Difficulties ◯ Y ◯ N

Medications _____ Pacemaker ◯ Y ◯ N Pregnant or Nursing ◯ Y ◯ N

HEALTH CONDITIONS None of the below ◯ or select all that apply:

◯ Uncontrolled Diabetes ◯ Rheumatoid Arthritis ◯ Psoriatic Arthritis ◯ Lupus ◯ Fibromyalgia ◯ Crohn's ◯ MS

◯ Ankylosing Spondilitis ◯ Cancer ◯ Scleroderma ◯ AIDS ◯ Other Immune Compromised Conditions

◯ Other _____

REFRACTION

Dry: OD _____ 20 / OS _____ 20 / ADD _____

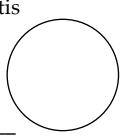
Wet: OD _____ 20 / OS _____ 20 /

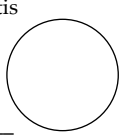
Stability: Has there been more than 0.50 D change in past year? ◯ Y ◯ N

CLINICAL EXAMINATION

Slit Lamp Exam

	OD	OS
Lids / Lashes:	◯ Clear ◯ Blepharitis	◯ Clear ◯ Blepharitis
Conj:	◯ White ◯ Injected	◯ White ◯ Injected
Cornea:	◯ Clear	◯ Clear
Neo: _____	/ 4 +	/ 4 +
Dry Eye (Schirmer, TBUT): _____		





Fundus Exam

	OD	OS
Lens:	_____	_____
Disc:	_____	_____
Macula:	_____	_____
Periphery:	_____	_____
IOP:	_____	_____

Comments _____

_____

Signature _____ **Date** _____