Refractive Consultation Request

ChuVision INSTITUTE

REFERRING DOCTOR

Name_____

Phone_____

Location_____

Date of Exam_____

PATIENT INFORMATION

Name _____

Address _____

_____

Date of Birth _____

Home Phone _____ Cell_____

Refractive Target OD_____ OS_____
Monovision OD_____ OS_____

SUBJECTIVE

Ocular history *(i.e., injury, amblyopia, previous surgery, other)* _____

Medical history *(i.e., diabetes, heart, lung, arthritis, lupus, pregnant, nursing, other)* _____

Medications: Ocular _____ Systemic _____

Allergies _____

OBJECTIVE

Corneal stability: ☐ Soft lens wearer ☐ RGP wearer ☐ Contacts out____week(s) before my cycloplegic refraction.

Important Note: *For accurate surgery, soft lenses must be left out at least 2 weeks prior and RGPs & Toric at least 3 weeks prior, or until corneal stability is confirmed.*

VA sc OD _____ Near VA sc OD _____

OS _____ OS _____

VA cc OD _____ Near VA cc OD _____

OS _____ OS _____

Present Glasses	Sphere	Cylinder	Axis	Add	Prism
OD					
OS					

Age of Rx: _____

Manifest	Sphere	Cylinder	Axis	Vision	Add	Near Vision
OD				20/		
OS				20/		

Cycloplegic	Sphere	Cylinder	Axis	Vision
OD				20/
OS				20/

Dominant Eye

If Available:

Pachymetry: OD Central _____

OS Central _____

Pupillometer: Scotopic OD _____ OS _____

Photopic OD _____ OS _____

Topography: OD ☐ Included OS ☐ Included

Recommendation to patient _____

Appointment: ☐ I have scheduled this patient to be seen at CVI on: (date) _____ at (time) _____

☐ I would like CVI to contact this patient to schedule an appointment.

Date Sent _____

Signed _____

Referring Doctor

CVI Phone 952.835.1235
Fax to CVI at 952.835.0534
Electronic forms are available at www.chuvision.com/eyecare-professionals