MILE HIGH EYE INSTITUTE

William Richheimer, MD

LASIK/PRK Pre-op form

Referring Doctor: _____

Patient Name: _____ DOB: _____

Co-managed: YES / NO

Patient interested in: (please circle) LASIK / PRK

Distance OU

Monovision (Refractive Target:_____)

Eyes: OD OS OU

Previous eye surgeries:

OD: _____

OS: _____

Glasses Rx: OD:_____

OS: _____

Contact Lens Rx / Type: OD: _____

OS: _____

RX Data		OD VA	OS VA	Date
Uncorrected VA				
MR#1 by:	Out of CTL x____ days	20/___	20/___	
MR#2 by:	Out of CTL x____ days	20/___	20/___	
Cyclo MR	Out of CTL x____ days	20/___	20/___	