TLC
Laser Eye Centers®

V8921
Office Use Only: Patent ID#________________

LASER VISION RETREATMENT EVALUATION FORM

Referring Doctors: Please fill out the Patient Refractive / Eye Health information below **and/or** send a copy of your comprehensive eye exam **including:**

1. **Cycloplegic Refraction**
2. **Dominant Eye**

Email results to LTC@tlcvision.com or fax to 513-725-1033. The medical team at TLC Laser Eye Centers (TLC) **requires** all patients seeking a retreatment obtain a comprehensive eye exam with a cycloplegic refraction to determine if a retreatment is medically appropriate and safe. TLC does not perform comprehensive eye exams.

PATIENT INFORMATION

Name: Date of Birth: Phone:

REFERRING DOCTOR INFORMATION

Referring Doctor: Practice Name:

Phone: Fax: Email:

PATIENT REFRACTIVE / EYE HEALTH INFORMATION

Date: ___________

Chief Complaint:

Best **Uncorrected** VA: OD: 20/___ OS: 20/___ OU: 20/___

Dry Refraction
OD___________________________________ 20/___
OS ___________________________________ 20/___

Wet/Cyclo Refraction:
OD___________________________________ 20/___
OS ___________________________________ 20/___

Circle Dominant Eye: **R** **L**

Any remarkable SLE Findings:

Any remarkable DFE Findings:

Other:

Please email results to LTC@tlcvision.com or fax to 513-725-1033