

LASER VISION RETREATMENT EVALUATION FORM

Email this completed form to ENH@Lasik.com or fax it to 513-792-5637. The medical team at the LASIK.com affiliated surgery center **requires** all patients seeking a retreatment to obtain a comprehensive eye exam **with a wet or cycloplegic refraction** to determine if a retreatment is medically appropriate and safe. Failure to complete all requested information will result in the form being rejected.

PATIENT INFORMATION

Name:

Date of Birth:

Phone:

OPTOMETRIST INFORMATION

Optometrist:

Practice Name:

Phone:

Fax:

Email:

PATIENT REFRACTIVE / EYE HEALTH INFORMATION

Date: _____

Chief Complaint:**Uncorrected VA:** OD: 20/____ OS: 20/____ OU: 20/____

Dry	OD	_____	20/____
Refraction	OS	_____	20/____

Wet/Cyclo	OD	_____	20/____
Refraction:	OS	_____	20/____

Circle Dominant Eye (circle one): **R** **L**

Any remarkable SLE Findings (circle one): Yes No

If yes, please explain: _____

Any remarkable DFE Findings (circle one): Yes No

If yes, please explain: _____

Other:

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