RESTORATIONEYECARE
TIMOTHY McGARITY, M.D.

Refractive Surgery Evaluation

Please fax this completed exam form or your own form to 573-441-2288
or call 573-441-7070 to schedule your patient

Patient's Name:_____ Date of Birth: _____

Co-Managing Doctor:_____

Reason for Referral:_____

Patient Interested In: **iLASIK** **Standard LASIK** **PRK** **ICL™-Phakic IOL** **Refractive Lens Exchange**

History: Circle any- Eye Rubbing, Allergic Conjunctivits, Dry Eyes, Keratoconus, Strabismus, Amblyopia, Unstable Refraction, Rheumatologic Disease, or Accutane/Anticholenergic usage.
Other History:
_____

Contact Lens History: Type/Date Discontinued?_____

VA (SC):	**VA (CC)**:	**Pachs**:
OD:_____	OD:_____	OD:_____um
OS:_____	OS:_____	OS:_____um

Current Spectacle Rx: **Date Glasses Changed or Stable Refraction?** _____
OD:_____ _____
OS:_____

Refraction (CycloRefraction Optional): ADD
OD:_____ VA:_____ _____ NVA:_____
OS:_____ VA:_____ _____ NVA:_____

IOP: OD _____ OS:_____ mm Hg @ _____am/pm

Slit Lamp Exam: (Print + or - and comment where applicable)

OD:		OS:
MDF or Scarring_____	Cornea	MDF or Scarring_____
Corneal Neo or other_____		Corneal Neo or other_____
_____	AC/Lens	_____
Flat_____ CSME_____ ARMD_____ Other_____	Macula	Flat_____ CSME_____ ARMD_____ Other_____
Intact/Attached_____ Other_____	Peripheral Retina	Intact/Attached_____ Other_____
Other _____	Other	Other_____

Impression: (___) Ammetrope type _____
(___) Other Conditions :_____

Plan: (____) Recommended Refractive Surgery Evaluation with Dr. McGarity.
(____) Recommended iLASIK, Standard LASIK, PRK, ICL or Refractive Lens Exchange

_____ _____
Optometric Physician's Signature Date

For emergency contact office 573-441-7070 Dr. McGarity's cell 573-268-7478 or Hospital 573-882-4141