

CLEARVIEW

PRE-OPERATIVE LASIK/PRK report

Patient Name: _____ **DOB:** m___/d___/y___ **Age:**___

Address: _____

Phone #: _____ **Appointment Date:** m___/d___/y___

- ❖ **Uncorrected VA:** **OU** 20/____ **OD** 20/____ **OS** 20/____ **Reading:** J_
- ❖ **Uncorrected VA:** **OU** 20/____ **OD** 20/____ **OS** 20/____ **Reading:** J_
- ❖ **Manifest Refraction:** **OD** _____ 20/____ **OS** _____ 20/____
- ❖ **Keratometry Readings:** **OD** K1___K2___AXIS___ **OS** K1___K2___AXIS___
- ❖ **Pachymetry** **OD** _____ **OS** _____
- ❖ **IOP** **OD** _____ mm Hg **OS** _____ mm Hg
- ❖ **Pupils** **OD** _____ **OS** _____
- ❖ **Anterior Segment**
- ❖ **Fundus**
- ❖ **Diagnosis**

Comments	
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Referring Doctor: _____

Signature: _____

Date: m___/d___/y___

Phone: _____ **Fax:** _____

Please Fax back to CLEARVIEW Institute at 416-289-2318 . Thank you.