

FAX this FORM and PATIENT'S MEDICAL RECORDS to AFFLECK EYE CARE



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REFERRING OD INFORMATION FORM

Referring Doctor \_\_\_\_\_ Date of Exam \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Address \_\_\_\_\_

Patient Phone Hm \_\_\_\_\_ Wk \_\_\_\_\_ Cell \_\_\_\_\_

Report Type

- Post-op Co-manage
- Referral
- Other \_\_\_\_\_

Referral Purpose

- Cataract Evaluation
- YAG
- Laser Vision Correction Screening
- Glaucoma Evaluation
- Peripheral Iridotomy
- Other \_\_\_\_\_

Ocular History \_\_\_\_\_

Chief Complaint \_\_\_\_\_

Significant Medical Problems \_\_\_\_\_

<b>OD</b>		<b>OS</b>
20/	Visual Acuity w/ Current SRx	20/
20/	Manifest Refraction (BVa)	20/
20/	Cycloplegic Refraction	20/
@	Keratometry	@
	Glare Va	
	Amsler grid	

<b>OD</b> (check box if normal)	<b>Significant Findings</b>	<b>OS</b> (check box if normal)
_____ <input type="checkbox"/>	Pupils EOM	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	Lids. Lacr	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	Conj/Sclera	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	Incisions	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	Cornea	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	AC/Iris	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	Lens	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	PC/Capsule	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	Fundus	_____ <input type="checkbox"/>

Notes: \_\_\_\_\_

- Affleck Eye Care to call patient for appointment
- Patient already scheduled at Affleck Eye Care

Date: \_\_\_\_\_

**Optometrist Confirmation:**

I have agreed to provide follow-up care for \_\_\_\_\_. I will see the patient after surgery or treatment when Dr. Aaron J. Affleck notifies me that she/he is releasing the patient to my care. I agree to notify Dr. Aaron J. Affleck immediately should complications arise and to provide written progress reports during my portion of the postoperative period.

Optometrist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CATARACTS**

Discussed with patient the following:

- Anatomy of eye       Definition of cataract       Explained Surgical treatment
- Lens options       Realistic results       Post-op care & Co-management

List patient lifestyle, hobbies, interests, work, and personal needs: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Recommend patient should be left mono vision
- Patient should have a myopic goal of \_\_\_\_\_
- Discussed with patient best lens option.    Lens recommended: \_\_\_\_\_

Why: \_\_\_\_\_  
\_\_\_\_\_

**LASIK/PRK**

Type of Contact:  Soft       Hard

Discussed with patient the following:

- Anatomy of eye
- Explained Surgical treatment
- Discontinue wearing contacts before screening. (3 days to 2 weeks for soft. 6 weeks for hard)
- Post-op care & Co-management (including separate payment)
- Realistic results
- Yes, I feel this patient is emotionally a good candidate. This patient is realistic about the treatment results and the reasons why they want treatment.
- I am unsure if this patient is emotionally a good candidate because:

\_\_\_\_\_  
\_\_\_\_\_