ADELAIDE eye&laser CENTRE

REFRACTIVE PRE OPERATIVE DATA FORM

Assessment Date: / /

PATIENT DETAILS

Name: ..... DOB: .....

Address: .....

Suburb: ..... State: ..... Postcode: ..... Telephone: .....

PATIENT HISTORY / SYMPTOMS

EXAMINATION DATA

	RIGHT EYE		LEFT EYE	
VAsc / VAcc				
Current Refraction				
If Hyperopic/Mixed Astigmatism Cycloplegic Refraction				
Has it been stable?	YES	NO	YES	NO

If PRESBYOPIC – does patient want monovision?	YES / NO
Has patient had a contact lens trial?	YES / NO
If yes, which eye is **for <u>near</u>**	RIGHT EYE / LEFT EYE

	RIGHT EYE	LEFT EYE
Keratometry K1		
Keratometry K2		
Comment on Anterior Segment	Normal ( )	Normal ( )
Comment on Posterior Segment	Normal ( )	Normal ( )
IOP		
Topography	YES – copy attached NO	
Pachymetry (if available)		

Any relevant past ocular findings / General comments

PRACTITIONER DETAILS

Date: *Signed:*

Please post or fax to Adelaide Eye & Laser Centre, 215 Greenhill Road, EASTWOOD SA 5063 Ph: 8274 7000 Fax: 8274 7099