MALONEY VISION INSTITUTE

PREOPERATIVE FORM

Please fax to (310) 208-0169 or email to: cm@maloneyvision.com

Referring Doctor: _____ **Date Seen:** _____

Patient's Name: _____ **Phone (Cell)** _____ **(Home)** _____

Reason for referral: _____

Relevant history: _____

_____

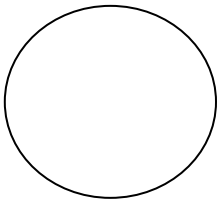
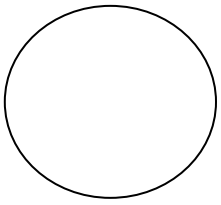
Contact lens history: _____

Length of time lenses were out before exam: _____
(RGP, HCL - 3 weeks minimum / SCL -3 days minimum)

EXAMINATION	**OD**	**OS**
Spec Rx	_____ **20/**_____	_____ **20/**_____
Uncorr V_A	**20/**_____	**20/**_____
Manifest Refraction	_____ **20/**_____	_____ **20/**_____
Cycloplegic Refraction	_____ **20/**_____	_____ **20/**_____

Ocular Dominance ❑ **Right** ❑ **Left** ❑ **Equal**

IOP _____ _____

	OD		**OS**
Ant Seg	_____	 	_____
Lens	_____		_____
Fundus	_____		_____

Diagnosis: _____

Recommendation/Plan: _____

Comments: _____

_____

Refractive Goal: **OD** _____ **OS** _____

_____
Doctor's Signature

Will you be performing your patient's one-day post-op exam?

❑ Yes ❑ No ❑ N/A