

PRE-PROCEDURAL  
FORM

Please fill out the information below &amp; Fax this form to 403.640.0456

Referring Doctor: \_\_\_\_\_ Patient name: \_\_\_\_\_  
Phone: \_\_\_\_\_ - \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Date of examination: \_\_\_\_\_ Phone: (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_  
E-mail: \_\_\_\_\_

List of Medication: \_\_\_\_\_ Allergies: \_\_\_\_\_  
\_\_\_\_\_

Comments/Chief Complaint: \_\_\_\_\_

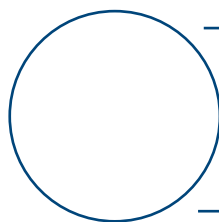
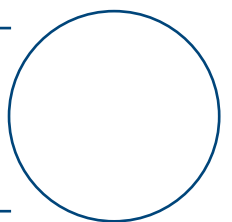
Ocular/Medical History: \_\_\_\_\_

Contact Lenses: ☐ RGP ☐ SCL Time CL were out before exam: \_\_\_\_\_  
Prisms: ☐ Yes ☐ No *SCL 7 days minimum/RGP or HCL 4 weeks minimum*  
Eye Dominance: ☐ OD ☐ OS

OD

OS

|          |          |                        |          |          |
|----------|----------|------------------------|----------|----------|
| _____    | 20/_____ | CURRENT SPECTACLES     | _____    | 20/_____ |
| 20/_____ | J _____  | UNCORRECTED VISION     | 20/_____ | J _____  |
| _____    | 20/_____ | MANIFEST REFRACTION    | _____    | 20/_____ |
| _____    | 20/_____ | CYCLOPLEGIC REFRACTION | _____    | 20/_____ |

|                                                                                     |            |                  |            |                                                                                       |
|-------------------------------------------------------------------------------------|------------|------------------|------------|---------------------------------------------------------------------------------------|
|  | _____      | K's              | _____      |  |
|                                                                                     | _____ mmHg | IOP's            | _____ mmHg |                                                                                       |
|                                                                                     | _____ mm   | PUPIL SIZE (Dim) | _____ mm   |                                                                                       |
|                                                                                     | _____      | SLIT LAMP EXAM   | _____      |                                                                                       |
| _____ FUNDUS _____                                                                  |            |                  |            |                                                                                       |

RECOMMENDATION / PLAN: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_