PRECILASER

Consultation Form

PH: 514-431-7373 FAX: 514-558-9804 Email: Admin@precilaser.ca

Referral to Doctor: _____

Patient Name:		**DOB:**	**Age:**
Address:	**City:**	**Postal:**	
Home Phone:	**Cell Phone:**		
Email:			
RAMQ:	**Gender:**	**Private Insur.**	

Medical Hx / Allergies:_____

Exam Date: _____

Wearing CL today? Yes__ **Type:** Soft__ Hard__ RGP__ **Date Last Worn:** _____

UCVA

OD 20/ __

OS 20/ __

Present Correction (Age of Rx: _____)

OD _____ X ____ 20/ __

OS _____ X ____ 20/__

Dominant Eye

OD __

OS __

Manifest Refraction

OD _____ _____ X _____ 20/

OS _____ _____ X _____ 20/

Cycloplegic Refraction

OD _____ _____ X _____ 20/

OS _____ _____ X _____ 20/

Pupil Size

OD _____ / _____

OS _____ / _____

Bright Dim

Corneal Thickness

OD _____

OS _____

IOP

OD _____

OS _____

Monovision Discussed: NO_ YES_

Comments: _____

Slit Lamp Examination:

OD

Fundus:

OS

Fundus:

Referring Doctor:		**License Number:**
Address:		**Email:**
Phone:	**Fax:**	**Comments:**