CLARITY
LASER VISION

PRE-PROCEDURAL
FORM

Please fill out the infromation below & 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: _____

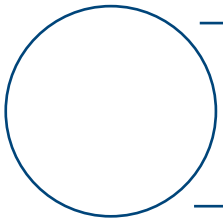
Contact Lenses: ☐ RGP ☐ SCL **Time CL were out before exam:** _____

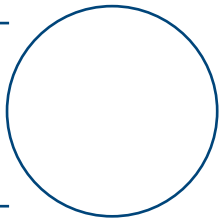
SCL 7 days minimum/RGP or HCL 4 weeks minimum

Prisms: ☐ Yes ☐ No

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: _____

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