PRE-OPERATIVE EXAMINATION FORM (FECC)

DATE: _____ CHART # : _____

PATIENT: _____ DOB (m/d/Y): _____

HISTORY

REASON FOR CONSIDERING: _____

_____

CAREER: _____ ACTIVITIES: _____

MEDICAL / OPHTHALMIC DISEASE / SURGERY OR MEDICATIONS:

_____

_____ **ALLERGIES:** _____

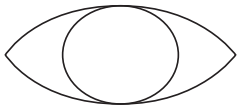
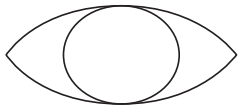
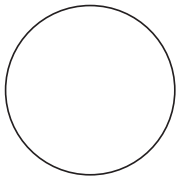
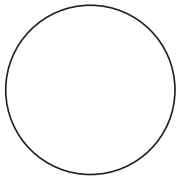
CL HISTORY: (type / longevity / hrs of wear and last worn) _____

_____

SCREENING

TYPE:	OD		OS
Autorefraction			
AutoKeratometry			
Lensmeter (Glasses)	_____/-_____x____	ADD:+ _____	_____/-_____x____
Uncorrected va	20/	nva: _____	20/
Manifest Refraction	_____/-_____x____	ADD:+ _____	_____/-_____x____
Best Corrected va (MR)	20/	nva: _____	20/
Cyclo Refraction +va	_____/-_____x____ 20/		_____/-_____x____ 20/
Pupil Size (mm)	Dim: _____ Med: _____ Bright: _____		Dim: _____ Med: _____ Bright: _____
IOP: (Tonopen)			

EXAMINATION

	OD	OS
Lids		
Iris / Pupil		
Cornea	 Pachy: _____	 Pachy: _____
Lens		
Retina		

COMMENTS

_____

_____

_____

RECOMMENDATION

1. ☐ OD ☐ OS ☐ OU

2. ☐ SBK ☐ SBK XTRA ☐ PRK ☐ PRK XTRA ☐ RLE WITH_____

OTHER PROCEDURE: _____

NEXT STEP

☐ BOOK ☐ SURGEON TO EXAMINE ☐ SURGEON TO REVIEW ☐ CYCLO REFRACTION REQUIRED

CHECKLIST

TOPIC:	YES	NO
Medical history complete		
Allergies identified		
Motivation explored and documented		
Does the patient have reasonable expectations		
Benefits of FECC discussed		
Single recommendation provided		
Benefits of recommendation provided		
Risks / Complications of recommendation provided		
Mitigation measures for complications		
Surgeon discussed		

SCREENING DOCTOR

SIGNATURE: _____ PRINT NAME: _____

DATE: _____