

REFERRING DOCTOR

Name _____
Address _____

Phone _____
Date of exam _____

PATIENT INFORMATION

Name _____
Address _____

Date of birth _____
Phone _____ Email _____

REASON FOR CONSULTATION ☐ LASIK ☐ PRK ☐ ICL ☐ RLE ☐ LASIK/PRK ENHANCEMENT

Vision preference for RLE: ☐ Premium vision ☐ Standard vision (single-focus IOL) ☐ Undetermined

Premium options: ☐ Astigmatism correction (toric IOL or LRI) ☐ Presbyopia correction (multifocal or extended-focus IOL with astigmatism correction if needed) ☐ Precision light adjustable lens (LAL)

REFRACTION

Manifest (date _____)
OD _____ 20/_____
OS _____ 20/_____
Cycloplegic (date if done _____)
OD _____ 20/_____
OS _____ 20/_____

CONTACT LENS WEARER ☐ Soft ☐ RGP

Your recent manifest and cycloplegic refractions are very helpful.
If they are to be used in surgery planning, soft contacts must be out
7 days before the refraction and RGPs **3 weeks** prior.

CENTRAL CORNEAL THICKNESS

OD _____ OS _____

RELEVANT CHART NOTES

Ocular and health history _____

DFE performed ☐ Unremarkable ☐ Relevant findings _____

Has a monovision trial or discussion about presbyopia occurred? ☐ Yes ☐ No

If a monovision trial has been completed, what is the desired target? _____

POST-OP CARE

I have discussed the importance of post-op care, and the patient understands the location is their choice.
Their expressed preference is:

- ☐ To return to me for post-op care
☐ For PCLI to provide post-op care
☐ Undetermined

BILLING FOR POST-OP CARE

Effective Now

☐ FOR COFI REGISTERED PROVIDERS:

This patient has agreed to pay for my post-op care when they pay for surgery. Note: If you are not a CoFi provider but want to get set up to use their service, go to www.cofimd.com/pcli

☐ NON-COFI PROVIDERS:

My fees have been declared to this patient and they understand that they will be billed for any post-op care I provide.