

Buckley Vision Institute

Patient Surgery Evaluation Exam

NAME: _____ EXAM DATE: _____

DOB: _____ AGE: _____ M F PHONE: (H): _____ (W): _____

ADDRESS: _____ CITY/STATE/ZIP: _____

OCCUPATION / VISION NEEDS AND GOALS: _____

REASON FOR SURGERY: _____

ISSUES DISCUSSED: _____

Probability of Outcome _____

PRESENT SYSTEMS: Spectacles ___% Soft ___% RGPs ___% worn Reading Rx Monovision
 No Near Rx Needed

UNAIDED VA: Distance: OD _____ OS _____ Near Point of Accommodation:
Near: OD _____ OS _____

CURRENT RX OR CONTACTS			
OD	VA 20/	ADD	VA 20
OS	VA 20/	ADD	VA 20
MANIFEST REFRACTION			
OD	VA 20/	ADD	VA 20
OS	VA 20/	ADD	VA 20
CYCLO REFRACTION			
OD	VA 20/	ADD	VA 20
OS	VA 20/	ADD	VA 20

DOMINANT EYE: R L

KERATOMETRY

OD _____ @ _____
OS _____ @ _____

TONOMETRY

OD_ mmHg Goldmann
OS_ mmHg Tonopen
 NCT

BIOMICROSCOPY: <input type="checkbox"/> Unremarkable	DILATED RETINAL EXAM: <input type="checkbox"/> Unremarkable
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OTHER: _____

Patient Referred For:

PRK OD OS
 LASIK OD OS
 REAL OD OS

SURGEON: Britt Buckley, M. D.

Refractive Goal: OD _____ OS _____

SIGNATURE: _____, OD

Please fax to (719) 227-9129 or mail to: 3155 North Union Boulevard, Colorado Springs, CO 80907
Our office will be happy to phone the patient to make surgery arrangements.

