

San Diego Eye Bank Excimer Laser Center
Patient Information

Patient Information

Name: _____

Surgery Date: _____

Date of Birth: _____

Address: _____

Sex: _____

Medical History

Exam Date: _____ Dominant Eye: OD / OS

Known Allergies: _____

Positive medical or surgery history: _____

If your patient has any of the following conditions or is taking the listing of medications, please circle.

Keratoconus, Collagen Vascular Disease, Autoimmune, Immunodeficiency Disease, Pregnant or Nursing, Taking Cordarone or Accutane

Pre-Operative Information - OD

Corneal haze: _____ IOP: _____

VA-sc: _____ VA-cc: _____ Pupil: Photopic _____ Scotopic _____

Previous ocular surgery: _____

Slit lamp exam: Normal / Abnormal **Dilated exam:** Normal / Abnormal

Diagnosis: Myopia / Hyperopia / Ast / _____

Keratometry: K1 _____ **AXIS** _____ **K2** _____ **AXIS** _____

Manifest:

Sphere	Cylinder	Axis

Cycloplegic:

Correction Desired:

WaveScan Refraction:

WaveScan Physician adj:

WaveScan Nomogram Adj.: _____

Correction: (Circle One)

PTK / PRK / PRKA / LASIK / HYP / HYPA / LASEK
CUSTOM / RETREAT RT W-RECU / FLAP LIFT ONLY

Vertex Distance: 12.50 / _____ mm **Hertz:** 8 10 _____

Blend Zone: Y N **Ablation Zone:** 6 / 6.5 / Hyp / Custom

Plate: 160 / 180 / 200 / _____ **Ring:** 8.5 / 9.5 / 8.5M / 9.5M

Intralase: Depth: _____ Diameter: _____

Pentacam / Topography to be done at Eye Bank? Yes No

If not done at SDEB: Normal / Abnormal **Pachometry:** _____

WaveScan completed: Y / N / NA Date: _____

Pre-Operative Information - OS

Corneal haze: _____ IOP: _____

VA-sc: _____ VA-cc: _____ Pupil: Photopic _____ Scotopic _____

Previous ocular surgery: _____

Slit lamp exam: Normal / Abnormal **Dilated exam:** Normal / Abnormal

Diagnosis: Myopia / Hyperopia / Ast / _____

Keratometry: K1 _____ **AXIS** _____ **K2** _____ **AXIS** _____

Manifest:

Sphere	Cylinder	Axis

Cycloplegic:

Correction Desired:

WaveScan Refraction:

WaveScan Physician adj:

WaveScan Nomogram Adj.: _____

Correction: (Circle One)

PTK / PRK / PRKA / LASIK / HYP / HYPA / LASEK
CUSTOM / RETREAT RT W-RECU / FLAP LIFT ONLY

Vertex Distance: 12.50 / _____ mm **Hertz:** 8 10 _____

Blend Zone: Y N **Ablation Zone:** 6 / 6.5 / Hyp / Custom

Plate: 160 / 180 / 200 / _____ **Ring:** 8.5 / 9.5 / 8.5M / 9.5M

Intralase: Depth: _____ Diameter: _____

Pentacam / Topography to be done at Eye Bank? Yes No

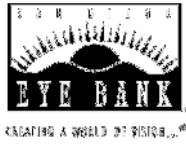
If not done at SDEB: Normal / Abnormal **Pachometry:** _____

WaveScan completed: Y / N / NA Date: _____

ALL AREAS MUST BE COMPLETED IF APPLICABLE PRIOR TO SURGERY

Physician's Signature: _____ **Physician's Phone:** _____ **Fax:** _____

9246 Lightwave Avenue Suite 120
San Diego, CA 92123



Phone: 858-694-0400
Fax: 858-565-7368

San Diego Eye Bank Excimer Laser Center
Patient Information

INSTRUCTIONS

Standard PRK, LASIK, LASEK or PTK

All areas need to be completed except for WaveScan refraction, WaveScan physician adj and WaveScan completed: Y or N

CustomVue

All areas need to be completed, however when entering in the treatment, complete only WaveScan refraction or WaveScan physician adj. Do not use Correction Desired.