



# WAVESCAN ORDER

Appointment Date/Time: \_\_\_\_\_ Physician: \_\_\_\_\_

**PATIENT INFORMATION**

Last \_\_\_\_\_ First \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( )  
 Telephone \_\_\_\_\_

**PROCEDURE & EYE:** (Please circle)

|           |         |
|-----------|---------|
| Pre-Op    | Post-Op |
| LASIK     | PRK     |
| OD        | OS      |
| Intralase | PTK     |
| OU        | OU      |

Diagnosis & History: \_\_\_\_\_

Pre-Op Information: **OD**

K1 \_\_\_\_\_ Axis \_\_\_\_\_ K2 \_\_\_\_\_ Axis \_\_\_\_\_

VAsc: 20/ \_\_\_\_\_ VAcc: 20/ \_\_\_\_\_

Manifest Rx:  
 Sph \_\_\_\_\_ Cyl \_\_\_\_\_ Axis \_\_\_\_\_ °

Vertex Distance: 12.5 / \_\_\_\_\_

Corneal Thickness (μ): \_\_\_\_\_

Scotopic Pupil Size (mm): \_\_\_\_\_

Pre-Op Information: **OS**

K1 \_\_\_\_\_ Axis \_\_\_\_\_ K2 \_\_\_\_\_ Axis \_\_\_\_\_

VAsc: 20/ \_\_\_\_\_ VAcc: 20/ \_\_\_\_\_

Manifest Rx:  
 Sph \_\_\_\_\_ Cyl \_\_\_\_\_ Axis \_\_\_\_\_ °

Vertex Distance: 12.5 / \_\_\_\_\_

Corneal Thickness (μ): \_\_\_\_\_

Scotopic Pupil Size (mm): \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Telephone: \_\_\_\_\_

**SDEB to collect payment for WaveScan: YES NO**

Mail results to Physician

Fax results to Physician

Patient to hand-carry results

Mail results to Physician