



Patient Referral

Date: _____

Doctor's Name: _____ Phone: _____

Contact Email: _____ Fax: _____

Preferred Method of Communication (circle one): Email Fax Letter

Patient's Name: _____ Phone: _____ DOB: _____

Please check your doctor preference:

- Teresa Carlson, OD Starck Johnson, MD Crystal Kasper, OD Ketty Lee, OD Mike Bollenbacher, OD
- Robert Prouty, OD Richard Stewart, MD Carl Tubbs, MD Thomas Cruse, OD *First Available*

Reason for Referral: Chief Complaint, Ocular History, Visual Acuity, Intraocular Pressures, etc.

Please Indicate:

InSight LASIK: Refractive Surgery Consult Cross-Linking Consult ICL Consult

Insight Vision Group: One-time Consult Diagnose and Treat This Problem Co-manage

Follow patient along with me Transfer Complete Management I will follow for Routine Care Only

Additional Services: Floater Treatment Consult Serum Tears

For Cataract Surgery Referrals Only: New technology IOLs, LenSx, and ORA were discussed with my patient and I recommend the following for my patient:

- Standard IOL Toric Package Restor Package LenSx ORA LenSx and ORA
- Trulign Toric-Accommodating Package Crystalens Package Symphony Package
- Monovision: Distance Eye is OD OS Mono Target: _____
- Who does post op Cataract care? Referring OD Surgeon's office
- Secondary Cataract YAG Treatment OD OS

If you would like us to do testing only, please circle what you would like done:

Visual Fields: Humphrey 24-2 - Humphrey 10-2

Nerve Fiber Analysis: Cirrus (Zeiss) or Avanti (OptoVue) OCT of ONH & macula scan (GCC)

Other: Avanti Angle OCT Scan - Digital fundus photos – Immersion A-scan – IOL master
High Resolution B-scan – Endothelial Cell Count – Pentacam

InSight LASIK

Parker - P: 720.880.6455 F: 720.880.6460 Boulder - P: 303.402.1000 F: 303.593.2199

Insight Vision Group

Parker - P: 303.794.1111 F: 303.347.1341 Lowry - P: 303.671.0000 F: 303.671.2879

Boulder - P: 303.402.1000 F: 303.593.2199

Fort Collins and Longmont - P: 303.485.1516 F: 303.776.1110



Referring Doctor: _____

Today's Date: ____/____/____

Date of Surgery: ____/____/____

Patient Name: _____

Date of Birth: ____/____/____

Surgeon: Starck Johnson Richard Stewart Carl Tubbs

Fax To: Parker 303.347.1341 Boulder 303.593.2199 Lowry 303.671.2879
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OD Date of Exam: ____/____/____ Post-op: 1 day 1 week 1 month 3 month other: _____

Type of IOL: _____ Post Op Goal: _____ Meds: _____ - _____

UCVA: 20/____ PH: 20/____ IOP: ____mmHg @ ____ am / pm MR: _____ x _____ 20/____

Cornea: Incision: Normal Open

Edema: None Trace 1+ 2+ 3+ 4+

Striae: None Trace 1+ 2+ 3+ 4+

Anterior Chamber: Cells/Flare: Clear Trace 1+ 2+ 3+ 4+

Pupil: Round Irregular

IOL: Centered Decentered

Posterior Capsule: Clear ____ + Haze ____ + Wrinkles

Macula: Clear CME other: _____

OS Date of Exam: ____/____/____ Post-op: 1 day 1 week 1 month 3 month other: _____

Type of IOL: _____ Post Op Goal: _____ Meds: _____ - _____

UCVA: 20/____ PH: 20/____ IOP: ____mmHg @ ____ am / pm MR: _____ x _____ 20/____

Cornea: Incision: Normal Open

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Anterior Chamber: Cells/Flare: Clear Trace 1+ 2+ 3+ 4+

Pupil: Round Irregular

IOL: Centered Decentered

Posterior Capsule: Clear ____ + Haze ____ + Wrinkles

Macula: Clear CME other: _____

Comments: _____

Dr. Signature: _____



Parker Fax: 720.880.6460
Boulder Fax: 303.593.2199

Patient

First Name: Last Name: Allergies: Age:

Pre-Surgery Evaluation

UCVA BCVA Zone Quick Pachymetry Pupil Size (scotopic) Dominant Eye OD OS APD Yes No Contact Lens Wearer? Yes No Type: Date Last Worn: Stable Yes No

Ocular Assessment

Tear Status Lids/Conj Cornea IOP Lens Disc Macula Peripheral Retina Pentacam/Topography

Doctor's Signature and Date

Name: Date F/U

Surgery Plan

OD OS OU LASIK PRK Primary Enhance Monovision: Yes No Near Eye OD OS Mono Amt.



Lasik Post-Op Evaluation

Referring Doctor: _____

Please FAX completed form to:
Parker: 720.880.6460
Boulder: 303.593.2199

Name (First/Last):	Age:	Surgery Date:	Primary Enhancement
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Exam Data

	OD	OS
	Goal:	Goal:
1 Day 10 Day 2 Mo Other: _____	History	Happy Unsure Unhappy
	Meds	AT's ____ x a day
	Acuity	UCVA 20/ UCVA 20/ UCVA OU 20/
	Refraction	20/ 20/
	Flap	Good SPK Debris Straie Good SPK Debris Straie DLK EI Other: _____
	Assessment	Good Unsure Enhance Good Unsure Enhance
	Plan	RTC InS CoMg RTC InS CoMg

Notes:

Today's Date _____ Doctor's Signature _____

Exam Data

	OD	OS
	History	Happy Unsure Unhappy
1 Day 10 Day 2 Mo Other: _____	Meds	AT's ____ x a day
	Acuity	UCVA 20/ UCVA 20/ UCVA OU 20/
	Refraction	20/ 20/
	Flap	Good SPK Debris Straie Good SPK Debris Straie DLK EI Other: _____
	Assessment	Good Unsure Enhance Good Unsure Enhance
	Plan	RTC InS CoMg RTC InS CoMg

Notes

Today's Date _____ Doctor's Signature _____



INSIGHT VISION GROUP

PRK/ASA Post-Op Evaluation

Referring Doctor: _____

Please FAX completed form to:

Parker: 720.880.6460

Boulder: 303.593.2199

Name (First/Last):	Age	Surgery Date:
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Exam Data

1 Day	OD							OS						
	Goal:							Goal:						
	3 Day	History	Happy	Unsure	Not Happy			Happy	Unsure	Not Happy				
	10 Day	Meds					AT's ____ x a day					AT's ____ x a day		
	1 Mo	Acuity	UCVA 20/				UCVA 20/				UCVA OU 20/			
	3 Mo	Refraction	20/				20/							
	6 Mo		20/				20/							
	Other:	Cornea												
		Assessment	Good	Unsure	Enhance			Good	Unsure	Enhance				
		Plan	RTC				InS	CoMg	RTC				InS	CoMg

Doctor's Signature:	Notes:	IOP @ _____
Today's Date _____		OD _____
		OS _____

Exam Data

1 Day		OD						OS						
	History	Happy	Unsure	Not Happy			Happy	Unsure	Not Happy					
	3 Day	Meds					AT's ____ x a day					AT's ____ x a day		
	10 Day	Acuity	UCVA 20/				UCVA 20/				UCVA OU 20/			
	1 Mo	Refraction	20/				20/							
	3 Mo		20/				20/							
	6 Mo	Cornea												
	Other:		Assessment	Good	Unsure	Enhance			Good	Unsure	Enhance			
		Plan	RTC				InS	CoMg	RTC				InS	CoMg

Doctor's Signature:	Notes:	IOP @ _____
Today's Date _____		OD _____
		OS _____