INSIGHT VISION GROUP

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:

☐Savannah Brunt, OD ☐Teresa Carlson, OD ☐Starck Johnson, MD ☐Crystal Kasper, OD ☐Ketty Lee, OD

☐Tom Politzer, OD ☐Robert Prouty, OD ☐Richard Stewart, MD ☐Carl Tubbs, MD ☐*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

For Cataract Surgery Referrals Only:

☐ New technology IOLs, LenSx, and ORA were discussed with patient
I recommend the following for my patient:

☐ Standard IOL ☐ Toric Package ☐ Restor Package ☐ LenSx ☐ ORA ☐ LenSx and ORA

☐ Trulign Toric-Accommodating Package ☐ Crystalens Package

☐ Monovision: Distance eye is ☐ OD ☐ OS Mono Target: _____

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

Visual Fields: Humphrey 24-2 - SWAP - Goldmann - FDT - Matrix

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 – Visante OCT

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 Longmont ~ P: 303.485.1516 F: 303.776.1110
Fort Collins ~ P: 303.485.1516 F: 303.776.1110 Lakewood ~ P:303.794.1111 F: 303.347.1341

INSIGHT VISION GROUP

LASIK/PRK/ICL Measurements

Parker Fax: 720.880.6460
Boulder Fax: 303.593.2199

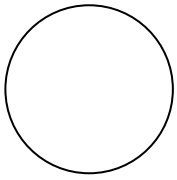
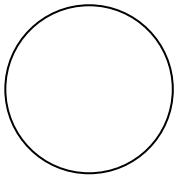
Patient

First Name:	Last Name:	Allergies:	Age:

Pre-Surgery Evaluation

	OD	OS		OD	OS	Date
UCVA	20/	20/	Current Rx	20/_____	20/_____	
BCVA	20/	20/	Manifest	20/_____	20/_____	
Zone Quick			Cycloplegic	20/_____	20/_____	
Pachymetry						
Pupil Size (scotopic)			WTW:	Dilation: Cyclogyl 1% 0.5% Trop. 1% Phen. 2.5% @		
Dominant Eye OD OS	APD Yes No		Pentacam or Other K's OD X / X OS X / X			
Angles Open Narrow	Contact Lens Wearer? Yes No		Type:	Date Last Worn:	Stable Yes No	

Ocular Assessment

	OD	OS		OD	OS		OD	OS
Tear Status	Normal Dry	Normal Dry	**Cornea**	Clear Opac Neo Dyst	Clear Opac Neo Dyst	**IOP**	____mmHg @_____	____mmHg @_____
Lids/ Conj	Normal Blepharitis	Normal Blepharitis				**Lens**	Clear Opacity	Clear Opacity
Disc	0. Rd. Tilted Myopic Conus	0. Rd. Tilted Myopic Conus	**Macula**	WNL Myopic Degen Other	WNL Myopic Degen Other	**Peripheral Retina**	WNL Lattice Holes Tear RD	WNL Lattice Holes Tear RD
Pentacam/ Topography	WNL CL Warpage Pathology	WNL CL Warpage Pathology						

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. _____	
					Ziemer	Allegretto		

INSIGHT VISION GROUP

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

Exam Data

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

Exam Data

		OD			OS		
1 Day	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

		OD			OS		
1 Day	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 _____

INSIGHT VISION GROUP

Cataract / YAG Post Op Form

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

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

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: _____

Comments:_____

_____

_____.

Dr. Signature: _____