Laser Refractive Surgery Waiver

Part 1 (To be completed by applicant):

Name:_____ SSN:_____

1. I last had laser refractive surgery performed on _____ (date) right eye
_____ (date) left eye

2. I do ____ do not ____ have difficulty with glare or haloes at night.
3. I do ____ do not ____ have difficulty with daily activities such as driving, reading signs at night, or beiing exposed to bright sunlight.
4. I do ____ do not ____ have double vision.
5. Please any topical eye drops/medication you are using or have used in the last month:

_____

Part II (To be completed by Optometrist/Ophthalmologist):

1. Pre-Laser Treatment Refractive Error _____(sph)_____(cyl)_____(axis) OD
(must be documented in pt record)
_____(sph)_____(cyl)_____(axis) OS

2. Post-Laser Treatment Refractive Error _____(sph)_____(cyl)_____(axis) OD

_____(sph)_____(cyl)_____(axis) OS

3. Type of corneal surgery: Photorefractive Keratectomy (PRK) _____
Laser-in-situ-Keratomileusis (LASIK) _____

4. Visual Acuity (Snellen) sc _____ OD _____ OS
cc _____ OD _____ OS

5. Eye Alignment (use Prism Diopters in Primary Position) _____
Eye Mobility: _____

6. Red/Green Color Blind _____ YES _____ NO Type of test:_____
7. Slit Lamp Exam of Cornea - Interface haze; rippling/displacement of flaps; scarring?

_____

8. Dilated Fundus Exam: _____

_____

9. Any additional observations/other relevant eye diagnosis (e.g. Keratoconus):

_____

_____

Signature: _____