## Laser Refractive Surgery Waiver

Vame:			SSN:	***************************************
. I last had laser refractiv . I do do not h	ned on	(date) (date)	(date) right eye.	
. I dodo noth night, or being exposed . I dodo noth . Please list any topical eyNONE	ave difficulty wi to bright sunlight ave double vision	th daily activities t.	such as driving	
art II. (To be completed	by Optometrist	/ Ophthalmolog	dst):	
. Pre-Laser Treatment Refra (Must be documented in pt record)	ractive Error	(sph)	(cyl)	(axis) OD
	**followepsec	(sph)	(cyl)	(axis) OS
Post-Laser Treatment Re	fractive Error	(sph)	(cyl)	(axis) OD
			(cyl)	
Type of comeal surgery:	Photorefractive Laser-in-situ-K	Keratectomy (P eratomileusis (L	RK)	
Visual Acuity (Snellen)	SC		OS OS	
Eye Alignment (use Prisme Motility:	Diopters in Prin	nary Position)		***************************************
Red/Green Color Blind	YES	NO Typ	e of Test:	
Slit Lamp Exam of Come				
Dilated Fundus Exam:				
Any additional observation	is / other relevan	t eve diagnosis (	.g. Keratoconus	1: 14

## ICL / Laser Refractive Surgery Waiver

## Part I. (To be completed by applicant):

Name:			SSN:				
1. I last had I	CL/Laser Refracti	ve surgery pe	rformed on	((	late) right eye. late) left eye.		
2. I do	do not hav	e difficulty w	ith glare or	haloes at night.			
3. I do	do not hav	e difficulty w	ith daily act	ivities such as c	lriving, reading		
signs at night	, or being exposed	to bright sun	light.		-		
4. I do	_do not hav	e double visi	on.				
5. Please list	any topical eye dro	ps/medicatio	n you are us	sing or have use	ed in the last		
month:							
	be completed by (						
1. Pre-ICL Treatment Refractive (must be documented in pt record)		ve Error	(sph)	(cyl)	(axis) OD		
(must be docum	ented in pt record)			(cyl)			
2. Post-ICL Treatment Refract							
				(cyl)			
3. Type of su	rgery: Implantable						
4. Visual Acu	ity (Snellen) sc						
<ol><li>Eye Alignr</li><li>Eye Motility:</li></ol>	nent (use Prism Di	opters in Prir	nary Positio	n)			
	Color Blind			No Type of To	est:		
	Exam of Cornea -						
8. Dilated Fur Exam;	ndus						
9. Any additio	onal observations /	other relevan	it eye diagno	osis (e.g. Kerato	oconus):		
Name / Title		Phone	Signat	ure	Date		