# Laser Refractive Surgery Waiver

**Part I. (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 being exposed to bright sunlight
4. I do ____ do not ____ have double vision.
5. Please list any topical eye drops/medication you are using or have used in the last month:
   ________NONE________________________________

**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 Motility: ______________________________________
6. Red/Green Color Blind ________YES ________ NO Type of Test: ______________
7. Slit Lamp Exam of Cornea – Interface haze; rippling/displacement of flap; scarring?
   ______________________________________________________
8. Dilated Fundus Exam: ______________________________________
   ______________________________________________________
9. Any additional observations / other relevant eye diagnosis (e.g. Keratoconus):
   ______________________________________________________
   ______________________________________________________

## ICL / Laser Refractive Surgery Waiver

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

Name: ______________________________ SSN: ____________________

1. I last had ICL/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 being exposed to bright sunlight.

4. I do _____ do not _____ have double vision.

5. Please list 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-ICL Treatment Refractive Error ______ (sph) ______ (cyl) ______ (axis) OD
(must be documented in pt record)
______ (sph) ______ (cyl) ______ (axis) OS

2. Post-ICL Treatment Refractive Error______ (sph) ______ (cyl) ______ (axis) OD
______ (sph) ______ (cyl) ______ (axis) OS

3. Type of surgery: Implantable Collamer Lens ______________________________

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

5. Eye Alignment (use Prism Diopters in Primary Position)____________________
Eye Motility: ____________________________________________

6. Red/Green Color Blind __________ YES __________ No Type of Test: __________

7. Slit Lamp Exam of Cornea - Interface haze; rippling/displacement of flap: scarring?

____________________________________________

8. Dilated Fundus
Exam:____________________________________________

____________________________________________

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

____________________________________________

____________________________________________

| ______________ | ______________ | ______________ | ______________ |
|---|---|---|---|
| Name / Title | Phone | Signature | Date |