DIXIE OPHTHALMIC SPECIALISTS
at Zion Eye Institute

1791 East 280 North
Saint George, Utah

(435) 688-2020
fax (435) 634-2646

Laser Vision Correction Referral

Date ______________ Co-Managing Dr. ___________________________ Phone ________________ FAX ________________

Patient Last Name First MI Age Sex DOB SS# Wk. Phone Hm Phone

Street Address City State ZIP Occupation

History: ____

____

Allergies:______________________________ Current Meds: ______________________________

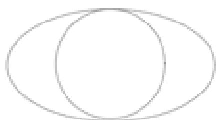
Visual History: Wore CL Y / N RGP Soft Date last worn _______ Monovision Y / N Dominant Eye OD / OS

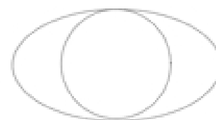
Visual Assessment	OD		OS	
Uncorrected VA	20/	Near	20/	Near
Corrected VA	20/	Near	20/	Near
Current Rx Age of Rx:		Add		Add
Auto Keratometry flat/steep @steep				
Manual Ks flat/steep @steep				
Pachymetry / IOP		IOP:		IOP:
Pupils	Dim	Bright	Dim	Bright
Manifest Ref.				
Cycloplegic Ref.				
Post Laser Target Rx				

OD Normal **EXTERNAL** Normal **OS**

☐ Lids & Lashes ☐
☐ EOMs ☐
☐ Muscle Balance ☐
☐ Irreg______ Rnd ____mm _____+react ☐ Pupils ☐ Rnd ____mm _____+react ☐ Irreg______

ANTERIOR SEGMENT

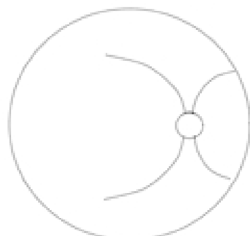


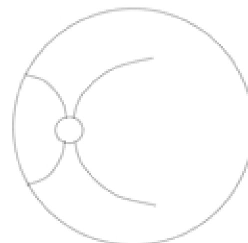


☐ Conjunctiva ☐
☐ Cornea ☐
☐ Tear Film ☐
☐ Ant. Chamber ☐
☐ Iris ☐
☐ Lens ☐

Dilation________ Cyclo________

POSTERIOR SEGMENT





☐ Vitreous ☐
C/D ___ ☐ Disc ☐ C/D ___
☐ Vessels ☐
☐ Macula ☐
☐ Peripheral Retina ☐

IMP: ____

PLAN: ____

Doctor Signature ______________________________ Date ________________

Please FAX completed form to 435-634-2646