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: _____

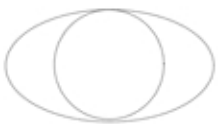
Allergies: _____ Current Meds: _____

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

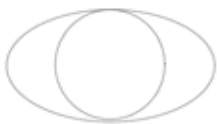
Visual Assessment	OD		OS	
Uncorrected VA	20/	Near	20/	Near
Corrected VA	20/	Near	20/	Near
Current Rx Age of Rx:		Add		Add
Auto Keratometry flat/steep @steep				
Manual Ks flat/steep @steep				
Pachymetry / IOP		IOP:		IOP:
Pupils	Dim	Bright	Dim	Bright
Manifest Ref.				
Cycloplegic Ref.				
Post Laser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

OD	Normal	EXTERNAL	Normal	OS
	☐	Lids & Lashes	☐	
	☐	EOMs	☐	
	☐	Muscle Balance	☐	
☐ Irreg_____ Rnd ____mm _____+react	☐	Pupils	☐	Rnd ____mm _____+react ☐ Irreg_____

ANTERIOR SEGMENT

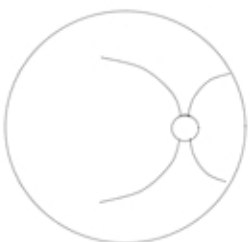


☐	Conjunctiva	☐
☐	Cornea	☐
☐	Tear Film	☐
☐	Ant. Chamber	☐
☐	Iris	☐
☐	Lens	☐

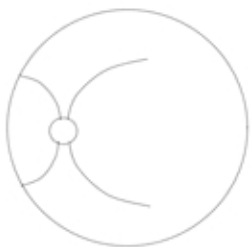


Dilation_____ Cyclo_____

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