MEI
MICHIGAN EYE INSTITUTE
By Midwest Vision Partners

Refractive Surgery Consult Request

Date: _____

☐ **David Diskin, M.D.**
☐ **Daniel St. Aubin, M.D.**
☐ **Abdala Sirajeldin, M.D.**
☐ **No Preference**

☐ **FENTON**
16255 Silver Parkway
Fenton, MI 48430
Phone: **(810) 629-7900**
Fax: **(810) 629-3937**

☐ **LAKE ORION**
1240 S. Lapeer Road, Ste. 100A
Lake Orion, MI 48360
Phone: **(248) 236-9379**
Fax: **(810) 496-4298**

Patient Name: _____ **DOB:** _____

Phone: _____ **E-Mail:** _____

For referral coordination line - Linda Darst at (810) 733-7111 x 1432 Fax 810-733-7141. One of our Refractive Surgical Couselors will contact the patient to schedule the appropriate appointment.

Refractive Information:
Current Spec RX Date: _____

OD: _____ 20/ _____

OS: _____ 20/ _____

Add: _____ ☐ BIF ☐ PAL

Latest Manifest Refraction Date: _____

OD: _____ 20/ _____

OS: _____ 20/ _____

Add: _____

Cycloplegic Refraction Date: _____

Please use 1% Cyclopentalate—at least 20 minutes prior to refraction

OD: _____ 20/ _____

OS: _____ 20/ _____

Current Contact Lens Rx Date: _____

OD: _____ 20/ _____

OS: _____ 20/ _____

Dominant Eye: ☐ OD ☐ OS

Monovision: ☐ Yes ☐ No

If yes, Target Near eye at: _____

Ocular Health:	**OD** **Normal**	**OS** **Normal**
Adnexa	☐	☐
Conj	☐	☐
Cornea	☐	☐
AC	☐	☐
IOP	_____ / _____ **Ta, TP, NCT, Icare**	
Lens	☐	☐
Optic Nerve	☐	☐
Cup/Disc	_____ / _____	
Macula	☐	☐
Vessels	☐	☐
Periph Fundus	☐ **Intact 360**	☐ **Intact 360**

The following are NOT all absolute contraindications, but should be considered. Please contact Linda regarding any refractive surgery concerns: **ldarst@midwestvision.com**

Binocular Dysfunction	Yes	No
☐ Strabismus ☐ Amblyopia ☐ Prism		
Refractive Change >0.50 x 1y	Yes	No
Pregnant	Yes	No
Autoimmune condition	Yes	No
(RA, Sjogrens, Lupus, Etc)	Yes	No
If yes, Controlled?	Yes	No
Diabetic?	Yes	No
If yes, Controlled?	Yes	No
Corneal disorders	Yes	No
Epith Basemt Memb Dyst	Yes	No
HSV / HZO	Yes	No
Keratoconus / Pellucid	Yes	No
Irregular Astig	Yes	No
Dry Eye		
If yes, ☐ Mild ☐ Moderate ☐ Severe		
Dry eye only associated with CL use	Yes	No
History of Restasis/Cequa/Xiidra	Yes	No
History of Punctal Plugs	Yes	No

Multifocal CLs
☐ Good ☐ Fair ☐ Poor ☐ Never Attempted

Monovision Trial
☐ CL ☐ In-office Demo Only ☐ Pt Declined
☐ Good ☐ Fair ☐ Poor ☐ Never Attempted

If Presbyopic, would you recommend Monovision? Yes No

Please describe any abnormal findings/additional comments:

_____

_____

_____

MEI will contact the patient above. Additional tests may be needed in order to choose the best procedure and treatment for this patient. We will return the patient to your care once the patient is medically stable and with their consent

Dr. Name: _____

Practice Name: _____

Office Phone Number: _____