

# AMJAD P. KHOKHAR, M.D.

Comprehensive Ophthalmologist  
Refractive Surgeon  
Board Certified  
Fellow, American Academy of Ophthalmology



## LASIK CONSULTATION REQUEST

This form is for use by an optometrist referring a patient for consultation on LASIK/PRK. For cataract consultation or any other eye consultation, consider using our Cataract Consultation Request form and General Consultation Request form respectively. **Download all forms at [www.SugarLandEye.com](http://www.SugarLandEye.com).**

Referring Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Surgery Date: \_\_\_\_\_ Age: \_\_\_\_\_  M  F

Pertinent History: \_\_\_\_\_

Expectations/Motivations: \_\_\_\_\_  Monovision? (Dominance?  R  L)

Contact Lens History: Type \_\_\_\_\_ Years Worn \_\_\_\_\_ Last Worn \_\_\_\_\_

**RIGHT:** UNVA= 20/ \_\_\_\_\_  
Specs: \_\_\_\_\_ X \_\_\_\_\_ =20/ \_\_\_\_\_  
Manif: \_\_\_\_\_ X \_\_\_\_\_ =20/ \_\_\_\_\_  
Cyclo: \_\_\_\_\_ X \_\_\_\_\_ =20/ \_\_\_\_\_  
Kerat: \_\_\_\_\_ @ \_\_\_\_\_, \_\_\_\_\_ @ \_\_\_\_\_  
Pupils: Dim \_\_\_\_\_ mm Bright \_\_\_\_\_ mm  
K: Pach \_\_\_\_\_ um Dia \_\_\_\_\_ mm

**LEFT:** UNVA= 20/ \_\_\_\_\_  
\_\_\_\_\_ X \_\_\_\_\_ =20/ \_\_\_\_\_  
\_\_\_\_\_ X \_\_\_\_\_ =20/ \_\_\_\_\_  
\_\_\_\_\_ X \_\_\_\_\_ =20/ \_\_\_\_\_  
\_\_\_\_\_ @ \_\_\_\_\_, \_\_\_\_\_ @ \_\_\_\_\_  
Dim \_\_\_\_\_ mm Bright \_\_\_\_\_ mm  
Pach \_\_\_\_\_ um Dia \_\_\_\_\_ mm

	<u>Normal</u>	<u>Abnormal</u>
	R	L
Lids/Lashes	<input type="checkbox"/>	<input type="checkbox"/>
Conj/Sclera	<input type="checkbox"/>	<input type="checkbox"/>
Cornea	<input type="checkbox"/>	<input type="checkbox"/>
Anterior Ch	<input type="checkbox"/>	<input type="checkbox"/>
Iris	<input type="checkbox"/>	<input type="checkbox"/>
Lens	<input type="checkbox"/>	<input type="checkbox"/>
Vitreous	<input type="checkbox"/>	<input type="checkbox"/>
Nerve	<input type="checkbox"/>	<input type="checkbox"/>
Macula	<input type="checkbox"/>	<input type="checkbox"/>
Vessels	<input type="checkbox"/>	<input type="checkbox"/>
Periphery	<input type="checkbox"/>	<input type="checkbox"/>
IOP Rt: _____	Left: _____	
Dilation _____	@ _____:	

### PLAN

Right:  
 LASIK ( Blade |  Bladefree)  PRK  
 Conventional  Custum  
 Far  Near

Left:  
 LASIK ( Blade |  Bladefree)  PRK  
 Conventional  Custum  
 Far  Near

Reviewed:  Infection  Inflammation  
 Flap complications  Loss BCVA  
 Glare/Haloes  Dryness  Presbyopia  
 Monovision  Enhancement  Stria

Comments: \_\_\_\_\_

Dr: \_\_\_\_\_ MD/OD Phone: \_\_\_\_\_ Please fax to (281) 240-0479

### LASIK SPECIALISTS - DISEASES & SURGERY - ADULT & PEDIATRIC

736 Highway 6 • Suite 101 • Sugar Land, Texas 77479  
[www.SugarLandEye.com](http://www.SugarLandEye.com) • [info@sugarlandeye.com](mailto:info@sugarlandeye.com)  
281-240-0478 Phone • 281-240-0479 Fax