



STEWART LASIK

Raindrop Patient Screening

Name _____

M F

Rec# _____

Date ____/____/____

Wears glasses for reading only? Y N Power: + _____

Wears glasses for DISTANCE vision? Y N

Any eye surgery or disease? Y N

Wears a contact lens for reading? Y N

Has tried mono-vision with CL? Y N Tolerated? Y N

EXAMINATION / DIAGNOSIS:

	OD	OS
Autorefraction	_____ SE_____	_____ SE_____
Dry Rrefraction:	_____ 20/_____	_____ 20/_____
Wet Rrefraction:	_____ 20/_____	_____ 20/_____
Penta/Orb Topo:	NL / Abnl	NL / Abnl
Penta/Orb Topo K/Pachs:	_____/_____ CP_____	_____/_____ CP_____
TBUT / Schirm:	Normal / Abnl	Normal / Abnl
SLE:	Normal / Abnl	Normal / Abnl
Non-Dominant Eye:	OD	OS
Photopic Pupil Diam:	_____ mm	_____ mm
Completed Trial CL:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A	<input type="checkbox"/> B&L <input type="checkbox"/> MF <input type="checkbox"/> 10L
Good Candidate for Raindrop:	<input type="checkbox"/> Y <input type="checkbox"/> N	

Surgeon: _____

Fee for Procedure: _____