ALOHA LASER VISION
People Of Vision

PATIENT REFERRAL for REFRACTIVE SURGERY

Date: _____ Referring OD: _____

Contact Person/Phone#: _____

PATIENT INFORMATION: (Please Print)

Patient Name: _____ Sex: ☐ M ☐ F

Street Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ Insurance: _____

Email Address: _____

Please circle all that apply:

Current Correction: Glasses Only Hard/RGP Daily Wear SCL Toric SCL

Patient Rx: OD _____ - _____ x _____ OS _____ - _____ x _____

Desired Surgery: LASIK PRK VISIAN ICL RLE OTHER

Desired Treatment: Distance OU Monovision

If Monovision, please specify: **OD –** Dist / Interm / Near **OS** – Dist / Interm / Near

Previous Eye Surgery: Yes / No If yes, type of surgery: _____

Would you like to Co-Manage?

☐ PRE OP & POST OP ☐ POST OP ONLY ☐ NO Co-Management

Comments:

PLEASE FAX TO: (808) 599-4818

1100 WARD AVENUE SUITE 1000 HONOLULU, HAWAII 96814 ✣ PHONE: 808.792.3937 FAX: 808.599.4818

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