



Alberta Eye MD
REFRACTIVE LENS EXCHANGE AND ICL
CO-MANAGEMENT FORM

(Available on our website)

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 www.albertaeyemd.com

* only use this form for RLE or ICL

DATE (MTH/DAY/YR) _____

CO-MANAGING DOCTOR INFORMATION

First name: _____ Last name: _____
 Telephone: - - _____ Fax: - - _____
 Referring clinic name: _____
 Preferred contact: Phone Fax Email for referral confirmations: _____

Male Female **PATIENT INFORMATION** English French

First and last name: _____ Date of birth (month/day/year): _____
 Home telephone: - - _____ Alt: - - _____ Email address: _____
 Address: _____ City: _____
 Province / State: _____ Postal / ZIP code: _____

PREFERRED SURGEON

Surgeon name: _____

OCULAR AND MEDICAL HISTORY

	OD	OS
UCVA:	20/	20/
MANIFEST:	20/	20/

	OD	OS
Anterior segment:	<input type="checkbox"/> Normal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Other: _____
Posterior segment:	<input type="checkbox"/> Normal <input type="checkbox"/> C/D: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Normal <input type="checkbox"/> C/D: _____ <input type="checkbox"/> Other: _____

GENERAL NOTES:

BV/Motility:

Normal
 Other: _____

	OD	OS
IOP		

I have discussed the following for:

OD OS OU

INTRAOCULAR SURGERY

Refractive lens exchange (RLE)
 Phakic IOL (ICL)

AIM

Plano OU Monovision

Target OD: _____

Target OS: _____

Wears contact lenses: Yes No

Soft RGP/Scleral

DOCTOR'S SIGNATURE
