

MALONEY VISION INSTITUTE

COMANAGEMENT PRE - PROCEDURAL FORM

Please Fax to (310) 208-0169 or mail to: 10921 Wilshire Blvd, Suite 900, LA, CA, 90024

Refer to: Dr. Maloney Dr. Devgan

VSP Patient

(Please Attach VSP - IDC Patient Record when faxing)

CoManaging O.D. M.D. _____ Date Seen _____

Patient _____ Phone (home) _____ (work) _____

Address _____ Soc.Sec. # _____

City _____ State _____ Zip _____ DOB ____/____/____ Sex: Male Female

Comments/Chief Complaint: Patient interested in decrease dependency in glasses and/or contacts.

Other _____

Ocular History: _____

Ocular Surgeries: _____

Contact Lens History: _____

Medical History: _____

Allergies: _____

Systemic Medication: _____

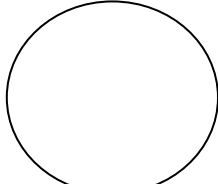
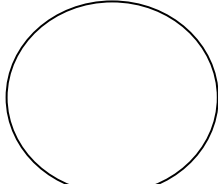
Ocular Medications: _____

Contact Lenses: _____ RGP, HCL
_____ SCL

Length of time lenses were out
before exam _____
(RGP, HCL - 3 weeks minimum / SCL -3 days minimum)

Monovision Successful in the Past: Yes No N/A

If yes, which eye: (For Near) OD OS

EXAMINATION	OD	OS
Spec Rx	_____ 20/ _____	_____ 20/ _____
Uncorr V _A	_____ 20/ _____	_____ 20/ _____
Manifest Refraction	_____ 20/ _____	_____ 20/ _____
Cycloplegic Refraction	_____ 20/ _____	_____ 20/ _____
Pupil Size (Dim Room)	_____	_____
Ocular Dominance	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Equal	
IOP	_____	_____
Exam		
	OD	OS
Ant Seg	_____ 	_____ 
Lens	_____	_____
Fundus	_____	_____

Name (patient): _____

(Please return pre-op form to MVI two days before consult when scheduling allows)

Refraction Stable for 1 year? OD: Yes No

OS: Yes No

Diagnosis: _____

Recommendation/Plan: _____

➤ **Please initial next to each area after your discussion with the patient:**

___ LASIK	___ PRK	___ Wavefront	___ Verisyse	___ Other
Pt's range	_____	Presbyopia/monovision? Y / N	_____	
Explain procedure	_____	Long term changes in vision	_____	
Wavefront procedure	_____	Dry eye/light sensitivity/fluctuation	_____	
No promise of perfect vision	_____	Glare/Halo/Gosting	_____	
Maximize freedom from spectacles	_____	OU same day / near vision vs. distance vision	_____	
Under/over response	_____	Loss of vision (blindness) – infection	_____	
May need correction after sx/LBCV	_____	Flap dislodgment/wrinkles, folds/epi/aborted	_____	
Enhancement dependency on RX	_____	Discuss Co-management	_____	
		Other	_____	

Other Discussion with Patient: _____

Refractive Goal: OD

Emmetropia

Other _____

OS

Emmetropia

Other _____

Question(s) to Surgeon: _____

Signature of O.D.

Note: Will you be performing your patient's one-day post-op exam? Yes No