BERG·FEINFIELD
VISION CORRECTION

CO-MANAGEMENT PRE-OPERATIVE FORM

Last Name: _____ First Name: _____ Age: _____

Gender: _____ DOB: _____/_____/_____ Phone (_____)_____ ❒Mobile ❒Home

Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Insurance: _____

SURGERY DATE: _____/_____/_____ **PROCEDURE/EYE:** _____

Quoted Price: $_____ **Referring Doctor:** _____

❒ One Year Enhancement Included OD Phone: _____

❒ With Lifetime Commitment OD Fax: _____

Chief Complaint/Comments: _____

Current Medications: _____

Allergies: _____

OD: _____20/_____ **Contact Lens Power** OS: _____20/_____

Contact Lenses: _____ RGP *(out for 4-6 weeks)* PMH: _____

_____ SCL *(sphere out for 5 days, Toric out for 7 days)* _____

Examination

OD		OS
_____	**Uncorrected Visual Acuity**	_____
_____20/_____	**Current Spectacles**	_____20/_____
_____20/_____ Add: _____	**Manifest Refraction**	_____20/_____ Add: _____
_____20/_____	**1% Mydriacyl Refraction** *(or 1% Tropicamide)*	_____20/_____
_____	**Keratometry**	_____
_____	Pachymetry *(if available)*	_____

Dominant Eye: _____

IOP: Right: _____ mm/Hg (time: _____) Pupil Size: Right: _____

Left: _____ mm/Hg (time: _____) *(Scotopic)*. Left: _____

_____ **Lids / Lashes / Lacrimal** _____

_____ **Conjunctiva** _____

_____ **Cornea** _____

_____ **Anterior Chamber** _____

_____ **Iris** _____

_____ **Lens** _____

C/D_____ **Macula** _____ **Dilated Fundus Exam C/D** _____ **Macula** _____

_____ **Periphery** _____

Plan: OD ❒ Distance ❒ Near (add: _____) Target Rx: _____

OS ❒ Distance ❒ Near (add: _____) Target Rx: _____

Recommendation/Plan: _____

_____

Doctor Signature: _____ Exam Date: _____

Revised March 2024

FAX TO 818.845.1916 or EMAIL TO info@bergfeinfield.com