Refractive Surgery Co-Management Request

Date: _____/_____/_____

Patient Name: _____

Address: _____

Phone Number: (_____) _____-_____

Birth Date: _____/_____/_____

Co-managing Doctor: _____

Office Location: _____

Phone Number: (_____) _____-_____

Fax Number: (_____) _____-_____

Surgeon Requested: _____

Have you performed a cycloplegic refractive surgery evaluation? _____

Would you like Shoreline to perform the cycloplegic refraction? _____

Would you like us to contact the patient to set up the appointment? _____

Refractive information:

_____

_____

_____

_____

_____

Patient's signature _____

Doctor's signature _____