Shoreline Vision
Vision Care. For Life.™

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 _____