

**NEW YORK EYE AND EAR INFIRMARY
OF MOUNT SINAI
OUTPATIENT LASER CENTER FORM
Telephone (646)943-7960 Fax (866) 500-3977**



NUR PHYSORD

PROCEDURE(S) _____ CPT CODE(S) _____	
SURGEON: _____ DATE OF SURGERY _____ REQ. TIME _____ AM PM	
Patient Last Name: _____ First Name: _____ (M F) Unit No. _____	
D.O.B.: _____ Age: _____ Marital Status (M S) S.S. No. ____/____/____	
Address: _____ APT. No.: _____ City: _____ State: _____ Zip: _____	
Telephone: (H) () (W): () EXT.: () (C): ()	
EMERGENCY CONTACT NAME: _____ Phone No. ()	
DIAGNOSIS (ES) For PRECERT	ICD-10 _____ ICD-10 _____ ICD-10 _____
Eye: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral Allergies: _____	
Primary Insurer _____	Secondary Insurer _____
Policy Holder's Name _____	Policy Holder's Name _____
Relation to Patient _____	Relation to Patient _____
Policy No. _____	Policy No. _____
Ins. Tel No. _____ Eff. Date _____	Ins. Tel No. _____ Eff. Date _____
If HMO, who is PCP _____	If HMO, who is PCP _____
PCP Tel. No. _____	PCP Tel. No. _____
Employer _____	Employer _____
Employer Tel. No. _____	Employer Tel. No. _____
PRECERT No. _____	PRECERT No. _____
Comments, No-Fault/Workers Comp. Information _____	
PHYSICIAN ORDERS: Eye drops: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both One drop Q ____ mins. X ____ Dose(s)	
<input type="checkbox"/> Mydrfrin 2.5% <input type="checkbox"/> Mydriacyl 1% <input type="checkbox"/> Iopidine 1% <input type="checkbox"/> Pilocarpine 2% <input type="checkbox"/> Proparacaine 0.5% <input type="checkbox"/> Pred Forte 1%	
Other Medications (list): _____ <input type="checkbox"/> IOP Measurement <input type="checkbox"/> Visual Acuity Measurement	
<input type="checkbox"/> No Orders Indicated	
Physician Signature: _____ Date and Time: _____	
Print or Stamp Name: _____	