ICL/RLE/IOL

Insurance: _____

Patient Name: _____ ❑ M ❑F Date: _____

Co-managing O.D.: _____❑N/A D.O.B.: _____/_____/_____ Age: _____

Motivation: ❑Contact Intolerance ❑Cosmetic ❑Lifestyle ❑Occupation ❑Other _____

C/L Wearer: ❑Yes ❑No Type: _____ Date Last Worn: _____ Mono C/L: ❑Yes ❑No

Past Ocular History: _____ Eye Medication: _____

Medical History: _____ Occupation: _____

Medications: _____ Hobbies: _____

Allergies: ❑NKDA _____

System Review: ❑Dry Eye ❑Recurring Red Eye ❑Ocular Herpes ❑Diabetes ❑RA ❑Retinal Tear ❑Pregnant ❑Nursing

Visual Complaint: _____

_____ Ocular Dominance: ❑O.D. ❑O.S.

OD	**OS**
_____ 20/_____ J_____ W Rx	_____ 20/_____ J_____Add_____
20/_____ J_____ VASC	20/_____ J_____ OU 20/_____ J_____
_____ Pupils (Scotopic Colvard)	_____
_____ 20/_____ MR (_____OD/ Tech.)	_____ 20/_____
_____ Monovision Trial	_____ ❑likes ❑dislikes
_____20/_____ BAT (Med.)	_____20/_____
(Dilation time:_____am/pm)	
_____20/_____ CR (gtt: ____)	_____ 20/_____
_____20/_____ Re√ MR	_____ 20/_____

Re√ MR OD/Tech:_____ Date_____

Schirmer's:

TBUT:
OD _____
OS _____

❑MB ortho/ortho
❑CVF Full
❑No APD
❑EOM Full

❑Orbscan Done
❑IOL Master Done
❑UBM Done (ICL)

SLE

_____ Lids _____

_____ Corneal Status _____

_____ AC _____

_____ Iris _____

_____ Lens _____

_____ Fundus _____

_____Cell count/Mosaic_____

_____ mm/Hg IOP _____ mm/Hg

_____ Manual Pachy. _____

_____ Goal _____

Physician Notes:

_____

_____

_____

_____

❑OU ❑OD 1ST ❑OS 1ST

❑In office ❑ASSC ❑Z

❑Drops ❑Dropless (DL)

_____❑LRI **Procedure** _____❑LRI

Informed Consent: Discussed Potential risks and side effects including: _____

_____

_____Signature: _____