

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 _____

SLE

_____ Lids _____

_____ Corneal Status _____

_____ AC _____

_____ Iris _____

_____ Lens _____

_____ Fundus _____

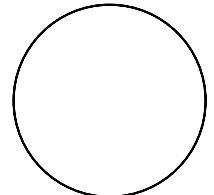
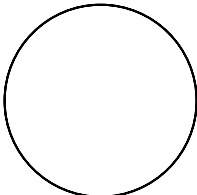
_____ Cell count/Mosaic _____

_____ mm/Hg IOP _____ mm/Hg

_____ Manual Pachy. _____

_____ Goal _____

Schirmer's:



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

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

TBUT:

OD _____

OS _____

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: _____