

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

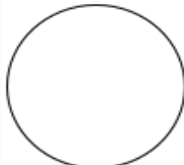
20/____ BAT (Med.) _____ 20/____

(Dilation time: _____ am/pm)

20/____ CR (gn: ____) _____ 20/____

20/____ Re√ MR _____ 20/____

Schirmer's:



Re√ MR OD/Tech: _____ Date _____

SLE

_____ Lids _____

_____ Corneal Status _____

 _____ AC _____

_____ Iris _____

_____ Lens _____

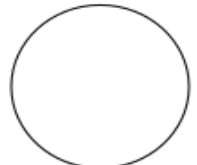
_____ Fundus _____

_____ Cell count/Mosaic _____

_____ mm/Hg IOP _____ mm/Hg

_____ Manual Pachy. _____

_____ Goal _____


Physician Notes:

 OU OD 1ST OS 1ST
 In office ASSC Z

 Drops Droplens (DL)

TBUT:

OD _____

OS _____

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

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

 LRI **Procedure**
 LRI

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

Signature: _____