(1)Dr. _____ Date _____

LEE _____ Tech _____

CL Brand & Rx _____

LTW _____ AWT _____

Comfort: good poor Vision: clear blurred

CC: EG / CL / BOTH _____

Patient Name: _____ DOB: _____ Age: _____

VA:

	Far Unaided	Far Aided	Near Unaided	Near Aided
OD:	20/	20/	20/	20/
OS:	20/	20/	20/	20/
OU:	20/	20/	20/	20/

IOP: NCT GAT OD _____ mm/Hg

Time: _____ OS _____ mm/Hg

1 gt Fluress @

Color Vision/Ishihara: OD ____/7 OS ____/7

Stereopsis _____ sec Binocular: Yes No

Phoria (H)_____XP / EP (V)_____RH / LH

Amsler Grid: OD Neg Pos OS Neg Pos

FDT: Patient Declined See Attached

RCI: Patient Declined See Imaging Fil VA

OD No Defect Other _____

OS No Defect Other _____

Blood Pressure: _____/_____ @ Time: _____

Hab RAS other: _____

Eg Rx	Sphere	Cyl	Axis	Add
OD				
OS				

Age Hab Rx: _____

CT: UCT _____ CF: OD FTFC Other: _____

c sc ACT _____ CF: OS FTFC Other: _____

EOM'S OD FROM other: _____

OS FROM other: _____

☐ Diagnostic Lenses ☐ See at Dispense ☐ Final Rx ☐ Follow-up Required ☐ I & R

CL RX	SPHERE	CYL	AXIS	BC	DIA	BRAND	OTHER
OD							
OS							

SUBJ RX	SPHERE	CYL	AXIS	PRISM/BASE	VA	ADD	VA
OD					20/____		20/____
OS					20/____		20/____

EG RX	SPHERE	CYL	AXIS	PRISM/BASE	VA	ADD	VA
OD					20/____		20/____
OS					20/____		20/____

NRA/PRA: _____ BCC: _____

Additional Testing:

Pupils:

Dim Light Reaction

OD _____ – _____ PERRLA _____

OS _____ – _____ PERRLA _____

RAPD: POS NEG OD OS

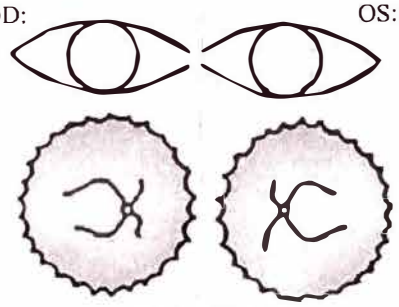
Contact Lens Fitting:

OD		OS
Good Poor	Comfort	Good Poor
Good Poor	Movement	Good Poor
◯	Rotation	◯
20/_____	Visual Acuity	20/_____

Slit Lamp Examination:

OD OTHER		OS OTHER
CL _____	Tears	CL _____
CL _____	Lids/Lashes	CL _____
CL _____	Cornea	CL _____
Q _____	Pal Conj	Q _____
Q _____	Bul Conj	Q _____
D/Q _____	Ant Chamber	D/Q _____
Flat _____	Iris	Flat _____
CL _____	Lens	CL _____
CL _____	Ant Vit	CL _____
0 1 2 3 4 4+	Angle Estimate	0 1 2 3 4 4+

OD: OS:



Peripheral Retina

FLAT ATTACHED FLAT ATTACHED

☐ RC Images N/A ☐ RC Images Reviewed

Fundus Examination: DO BIO 90D 78D MIO

OD OTHER		OS OTHER
Norm, Caliber _____	Vessels	Norm, Caliber _____
2/3 _____	A/V	2/3 _____
CL _____	Media	CL _____
CL _____	Macula	CL _____
Flat, Norm _____	Post Pole	Flat, Norm _____
CL _____	Vitreous	CL _____
Distinct _____	Disc Margins	Distinct _____

☐ Yes Foveal Light Reflex ☐ Yes

◯ _____ C/D Ratio _____ ◯

Dilation @ _____ Patient Refused

.5% Proparacaine % Tropicamide Paramyd

2.5% Phenylephrine 1% Cyclopentolate

Other: _____

Patient R/S _____

Assessment: Hyperopia (H52.03) Myopia (H52.13) Astigmatism (H52.209) Presbyopia (H52.4) Amblyopia (H53.009) Acute Conj. (H10.9) Blepharitis (H01.009) Cataract Unspecified (H26.9) Chalazion (H00.19) Corneal Ulcer (H16.009) Diabetes w/o Comp. (E11.9) Diabetic Ret. (E11.319) Glaucoma Suspect (H40.0) Glaucoma Unspecified (H40.9) GPC (H10.419) Hypertensive Ret. (H35.039) Mac Deg (H35.30) SPK (H16.149)

Additional Diagnosis:

Discussed:

		Return to Clinic:	
Astig & Va	Torics	1 Day	2 Days
Poor Cand	RGP's	1 Week	2 Weeks
Presbyopia	DW only	1 Month	2 Months
Refer MD	Decrease WT	3 Months	6 Months
Rec. B/U EG	MWT 2 wks	1 Year	2 Years

Plan:

Doctor Signature: _____ **Date:** _____