CONTACT LENS EVALUATION

Patient Name _____ DOB _____ Date _____ Chart # _____

CONTACT LENS HISTORY

Current Lenses (brand / Rx)	Modality / Wear Time	Solutions / Care	Comfort / Complaints

TRIAL LENSES / OVER-REFRACTION

#		Power (Sph / Cyl / Axis)	Brand / BC / Diam	VA	Over-Refraction	OR VA
1	OD					
	OS					
Comments / Fit:						
2	OD					
	OS					
Comments / Fit:						
3	OD					
	OS					
Comments / Fit:						

FINAL CONTACT LENS Rx

	Power (Sph / Cyl / Axis)	Brand / BC / Diam	Add	Supply / Replacement
OD				
OS				

DISPENSING / CARE

Wear Schedule: _____ **Replacement:** _____ **Care System:** _____

I&R Training: ☐ completed ☐ scheduled ☐ n/a **Dispensed:** ☐ trial lenses ☐ Rx lenses **CL Rx released:** ☐

ASSESSMENT & PLAN

_____

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RTC: _____ **Signature:** _____ **Date:** _____

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