

Contact Lens Follow-Up Form

Date:

Diagnostic CL: Brand/BC/Power

Patient Name:

OD:

OS:

S: CL Check No Chief Complaint WT: AWT: Sol:
OD OS

No c/o
Blur
Red
Irritate
Dry
Other

O: DVAcc: NVAcc: OR: Rotation/Movement SLE: All WNL
OD20/ 20/ OD OS LLL
OS20/ 20/ OS OS Cornea
A.C

Additional DxCL needed:

Brand/BC/Pwr

VAcc:

OR:

Notes:

OD

20/

OS

20/

A: Good Fit/Comfort/VA OU No Contraindications to CL wear

P: Release CL Rx RTC 1 wk 1 day 1 yr/PRN Other _____

X: _____ No Fee Fee

DATE:

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