BOSTON VISION

Please return Completed form via email or fax
Email: MyPatient@bostonvision.com
Fax: 617-860-6891

LVC Consultation Form

*required test fields - not all portions need to be filled

Co-Managing Doctor:_____ Contact Person: _____

Patient Name: _____ Consult Date: _____

Date of Birth: _____ Phone Number: _____

Last time CL's worn?: _____ Type: _____

Tolerance: OD ☐ Good _____ OS ☐ Good _____ ☐ No dry eye out of CLs _____

Dominant Eye? OD ☐ OS ☐ Pupil Size (Dark): _____/_____mm EOM full? ☐ PERRL? ☐

*** Vision w/o Correction:**

	DVA	NVA
OD	sc:	sc:
OS	sc:	sc:

*** Current Rx:** (_____old) wears (%)

	VA	AR
OD		
OS		

Comments: _____ Comments:_____

*** MR:**

OD		20/
OS		20/

*** Cyclo:**

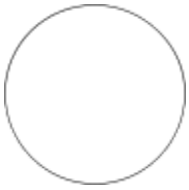
OD		20/
OS		20/

Dilated 1% T or: _____

Topo or Keratometry (attached):
OD: ☐ WNL
_____
OS: ☐ WNL
_____

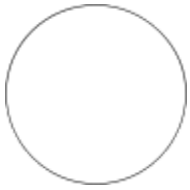
Pach:
OD: _____
OS: _____

*SLE

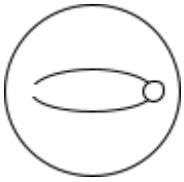


WNL
_____
_____
_____
_____
_____
_____
_____

	WNL
Ext	_____
Lids	_____
Conj	_____
Cornea	_____
Iris	_____
AC	_____
Lens	_____

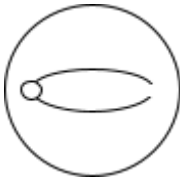


DFE*



WNL
_____
_____
_____
_____
_____

	WNL
C/D	_____
Rim	_____
Macula	_____
Vessels	_____
Periph	_____



Assessment:Patient is interested in (One or more):
☐ LVC - (Patient Preference ☐ LASIK ☐ PRK)
☐ Phakic IOL
☐ CLE

Monovision: Patient Has experience with monovision
☐ Yes
☐ No

Co-management:
☐ Co-management arrangements explained