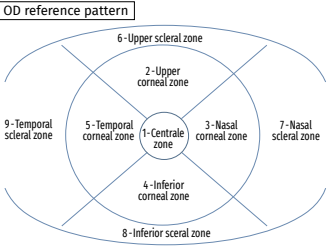


OPTIMIZATION SHEET

Gas permeable lenses

Client account		Patient reference		Delivery order n°	
Practitioner		Email		Date	
Comfort / Patient satisfaction		Number of wearing days		Number of hours of lens wear	
Overview					

Lenses worn*											
Material + color tints	OD:				OS:						
Geometry	<input type="checkbox"/> Spheric		<input type="checkbox"/> Front toric		<input type="checkbox"/> Back toric		<input type="checkbox"/> Bitoric				
Design	<input type="checkbox"/> PRE PERFORM	<input type="checkbox"/> PRE AS XL	<input type="checkbox"/> PRE DS	<input type="checkbox"/> PR2	<input type="checkbox"/> MVB	<input type="checkbox"/> Other:					
Contact Lens Care	<input type="checkbox"/> OXYClean	<input type="checkbox"/> B5	<input type="checkbox"/> AQUADROP+	<input type="checkbox"/> ProCare		<input type="checkbox"/> Other:					
Parameters	OD :				OS :						
Visual acuity	OD :				OS :						
Over refraction	OD :				OS :						
Slit Lamp observation						OD	OS				
For toric lens, indicate the stabilization axis of the dots position											
Vertical centration*	Optimal				<input type="checkbox"/>	<input type="checkbox"/>					
	Upper	Acceptable				<input type="checkbox"/>	<input type="checkbox"/>				
		Unacceptable (exceeding limbus)				<input type="checkbox"/>	<input type="checkbox"/>				
		The lens comes down when the upper eyelid is lifted	Yes			<input type="checkbox"/>	<input type="checkbox"/>				
			No			<input type="checkbox"/>	<input type="checkbox"/>				
	Lower	Acceptable				<input type="checkbox"/>	<input type="checkbox"/>				
Unacceptable (exceeding limbus)				<input type="checkbox"/>	<input type="checkbox"/>						
Horizontal centration*	Optimal				<input type="checkbox"/>	<input type="checkbox"/>					
	Nasal	Acceptable				<input type="checkbox"/>	<input type="checkbox"/>				
		Unacceptable (exceeding limbus)				<input type="checkbox"/>	<input type="checkbox"/>				
	Temporal	Acceptable				<input type="checkbox"/>	<input type="checkbox"/>				
		Unacceptable (exceeding limbus)				<input type="checkbox"/>	<input type="checkbox"/>				
Movement*											
Fluorescein pattern *	Central			Optimal				<input type="checkbox"/>	<input type="checkbox"/>		
				Steep				/100	/100		
				Flat				/100	/100		
	Insert OD	Insert OS	Peripheral		Optimal				<input type="checkbox"/>	<input type="checkbox"/>	
Flat meridian					<input type="checkbox"/> Steep <input type="checkbox"/> Flat	/100	<input type="checkbox"/> Steep <input type="checkbox"/> Flat	/100			
Steep meridian					<input type="checkbox"/> Steep <input type="checkbox"/> Flat	/100	<input type="checkbox"/> Steep <input type="checkbox"/> Flat	/100			
Wettability											
General slit lamp examination				3 and 9 o'clock staining	No	<input type="checkbox"/>	<input type="checkbox"/>				
					Yes						
						Position	Grade	Position	Grade		
Comments / Questions											

* Required fields

SEND