

ID#: _____ Name: _____

Dilate OD OS

Caller: _____ Phone: _____ Work: _____

RK OD OS

Dr.: _____ Taken By: _____ Date: _____ Time: _____

NCT OD OS

OD? OS? OU? Do You Wear Contacts?

New	Insert	Copy
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FDT OD OS

Problem? _____

Vision Affected? How? _____

How Long? _____

Pain? Dull? Aching? Throbbing? Constant? Sharp? Uncomfortable?

Discharge? Spots? Dry? Itchy? Red? Flashes? Light Sensitive?

Field Loss? Diabetic? Other: _____

Ever Happen Before? When? _____

How was it Treated? _____

What have you done now? _____

Notes: _____

Fees: _____ Dilation: _____

Appointment Booked? _____ Follow-up call: _____

Notes: _____

- EMERGENCY:**
- Chemical burns
 - Sudden, severe, painless loss of vision
 - Penetrating trauma

- URGENT:**
- Corneal foreign body
 - Severe eye pain
 - Blurred vision & halos around lights
 - Blow to the eye
 - Pain around & behind the eye
 - Pain, photophobia & reduced vision
 - Severe CL problems

- SEMI URGENT:**
- Chronic redness
 - Chronic double vision
 - Styes & chalazions
 - Unilateral protrusion
 - Broken glasses
 - Minor CL problems
 - Headaches