clarity eye

Co-Management Reporting Form

Patient Name

OD Information

Visiting Date _____

2-4 Weeks Post Treatment ☐

Other: _____

Treatment Date: _____

Type of Dry Eye Questionnaire: _____

Dry Eye Questionnaire Score: _____

Send Questionnaire results to: *dryeyes@clarityeye.ca*

OD	OS
Corneal Surface: _____	Corneal Surface: _____
Lid Appearence: _____	Lid Appearence: _____
Gland Expression: _____	Gland Expression: _____

Doctor's Comment:

Excellent ☐ Stable ☐

Other:

Subjective Complaint :

IPL Recommended Maintenance Dose: ☐4 Months ☐6 Months ☐ 12 Months Other _____