clarity eye

Opti-K™

OPTI-K REPORTING FORM

Co-Management Reporting Form

Patient Name

OD Information

Visiting Date _____

1 Month Post Treatment ☐

Other: _____

Opti-K Treatment Date: _____

OD	OS
BCVA: _____	BCVA: _____
BCNVA: _____	BCNVA: _____
UCDVA: _____	UCDVA: _____
UNDVA: _____	UNDVA: _____
Contrast Sensitivity: _____	Contrast Sensitivity: _____
IOP: _____	IOP: _____
SLE: _____	SLE: _____
Manifest Refraction: _____	Manifest Refraction: _____

Doctor's Comment:

Excellent ☐ Stable ☐

Other:

Subjective Complaint :

Our vision is excellence.

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