CLINIQUE D'OPTOMÉTRIE SD&G OPTOMETRY CLINIC
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DRY EYE CONSULT REQUEST FORM

Please complete this form, or send a letter with all information requested here included

Patient name: _____ DOB (DD-MM-YY): _____
Address: _____ City: _____
Postal Code: _____ Email: _____
Home Phone: _____ Cell Phone: _____
Last Comprehensive Exam Date (DD-MM-YY): _____ Gender: _____

Medical history / current medications: _____
_____
Ocular conditions diagnosed: _____

Dry Eye Symptoms:

☐ Burning ☐ Itching ☐ Tearing ☐ Redness ☐ Foreign body sensation ☐ Light sensitivity ☐ Pain
☐ Other: _____

Examination findings:

Present Correction

OD Habitual VA: _____ ☐ cc ☐ sc BCVA: _____ ☐ CL wearer?
OS Habitual VA: _____ ☐ cc ☐ sc BCVA: _____ Modality: _____

Slit Lamp Examination

Anterior Segment: _____
_____
_____
Posterior Segment: _____
_____
_____

Current Ocular Surface Disease Treatments (prescribed/recommended):

☐ Warm compresses ☐ Lid scrubs ☐ Artificial tears ☐ Omega 3 supplements ☐ Punctal plugs
☐ Topical medications – Which one(s)? _____
☐ Other _____

Referring Doctor: _____
Address: _____ Email: _____
Phone: _____ Fax: _____