EF 8.2

DIAGNOSTIC CONTACT LENS EXAM

CPT Code 92310

Patient Name | Date

CONTACT LENS HISTORY (wearing schedule, solutions, work conditions, etc.)

_____

_____

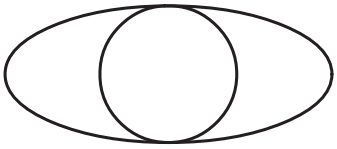
DIAGNOSTIC CONTACT LENSES (prescription of optical and physical characteristics)

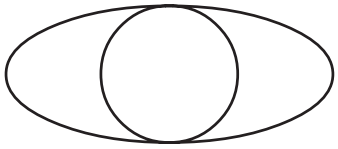
_____

_____

Cornea _____

Right Eye





Left Eye

Conjunctiva _____

Tear Film _____

Eyelids _____ Sclera _____

OBJECTIVE and SUBJECTIVE RESPONSES

Abnormal Blinking	Excessive Tearing	Comfort	Lens Movement	Lens Centration
☐ Yes	☐ Yes	☐ Good	☐ Good	☐ Good
☐ No	☐ No	☐ Bad	☐ Bad	☐ Bad

OVER-REFRACTION

O.D. _____ 20/_____ O.S. _____ 20/_____

DISPENSING (instructions for lens care, handling, wearing schedule)

_____

_____

_____

Doctor's Signature _____

EYEFORMS