Consultation Request Checklist

Please provide the following information to the SpecialEyes consultation team to re-order trial lenses for your patient. Contact us via phone at 866.822.2020 or submit your request online via our Consultation Request form.

Patient Name:

CONTACT LENS FIT

	OD	OS
Current Contact Lens Rx		
Centered	❑ Yes ❑ No	❑ Yes ❑ No
Movement	❑ Optimal (.25–.75 mm) ❑ Excessive ❑ Minimal	❑ Optimal (.25–.75 mm) ❑ Excessive ❑ Minimal
Limbal Coverage	❑ Optimal (1–2 mm) ❑ Excessive ❑ Minimal	❑ Optimal (1–2 mm) ❑ Excessive ❑ Minimal
Rotation	_____ deg. ❑ CW ❑ CCW ❑ Stable ❑ Unstable	_____ deg. ❑ CW ❑ CCW ❑ Stable ❑ Unstable

VISION

VA with Contact Lenses	OD: 20/_____ @Dist. OS: 20/_____ @Dist. OU: 20/_____ @Dist.	20/_____ @Near 20/_____ @Near 20/_____ @Near
Distance Over-Refraction	OD:_____ OS:_____	20/_____ 20/_____
Near Over-Refraction	OD:_____ OS:_____	20/_____ 20/_____

Comments / Chief Complaint

specialeyes