35 Amy Croft Drive, Tecumseh, ON | PHONE: (519) 997-2361 | **FAX: (519) 968-3695** | orbitcontactlens.com

ORTHO-K CONSULT

FAX TO: (519) 968-3695

Today's Date (m)_____(d)_____(y)_____

PATIENT

First Name: _____ Last Name: _____DOB:(m)_____(d)_____(y)_____

Address: _____ Apt:_____

City: _____Province: _____Postal Code: _____

Mother's name _____ Phone _____Main Contact ☐

Father's name _____ Phone _____Main Contact ☐

CHECK ALL THAT APPLY

____Emerging Myopia
____Progressing Myopia
____Good ocular health
____Family History of myopia / high myopia
____Patient advised to begin myopia control
____Cleared for Ortho-k
____Previous Ortho-k patient / refit
____Other History_____

FROM

Doctor: _____

Practice: _____

Phone: _____

Fax: _____

Notes: _____

_____

CURRENT RX

EXAM DATE (m)_____(d)_____(y)_____

	SPH	*CYL*	*AXIS*	*ADD*	*PRISM*
OD					
OS					

_____

REFERRING DOCTOR

*A report will be submitted to you when the corneal molding process is completed and the patient enters retainer stage.
Patients will be sent back to the provider for a corneal health check up, refraction and continued annual exams.