

NAME:

DOB:

DATE OF ASSESSMENT:

Measured Eye Dominancy:

Manifest Refraction At Time of Assessment:

OD: -1.25 -0.75 x 126

OS: -2.00 0.00 x 0

Dear Colleague:

The above patient was seen at the Gimbel Eye Centre for a Refractive Assessment and is considering Refractive Surgery. At the time of the assessment, **monovision was discussed in detail with this patient.**

Due to the fact that contact lens fitting is your area of expertise, we would appreciate your help in fitting this patient with a monovision contact lens trial to ensure adaptation. The patient was made aware that they will be charged a contact lens fitting fee.

We would appreciate it if you could supply the following data for our records:

Final Monovision Contact lens Info:

Contact lens Brand: _____ Base Curve: _____

Contact lens Power: OD _____ OS _____

Monovision Over-Refraction Info:

CL Overrefraction: OD _____ OS _____

***** This is especially important to confirm in light of vertex changes, tear film influence, and masking of astigmatism.**

If you would please forward this information to our office, it would be most appreciated. Thanks for being an integral part of this patient's surgery experience. Our fax number is (403) 286-2943.

If you have any further questions or concerns, please feel free to contact our centre at (403) 202-3333.

Best regards,