Contact lens telephone review

Patient name:		Patient identifier:	
Date of birth:		Practitioner:	
Date of last CL aftercare:		Date of last sight test:	

Existing lens type:		Solutions:
Additional notes to confirm the need of the telephone consultation:		

Existing contact lens specification		
Right:		Previous VA
Left:		Previous VA

Telephone consultation

Do you have current concerns about your contact lenses or eye health?	
How is your vision when wearing contact lenses?	
Any other questions?	
How is the comfort of your contact lenses? Wearing / On removal	
How many hours a day do you wear your lenses?	AVG / MAX
How many days do you wear your lenses?	AVG / MAX

Have you experienced any of the following?	
Redness:	
Discharge:	
Light sensitivity:	
Pain:	
General health:	
Are you happy with how to use your cleaning solutions correctly?	
Comfort drops:	

Patient education check list

No tap water or swimming in lenses	
No sleeping in contact lenses	
No sharing or over wear	
Reminder to remove lenses in the event of pain, blurred vision or a red eye	

Recommendations

How many CLs may be supplied?	Date when CL aftercare recommended?
Remind patient if contact lenses do not perform as expected, should remove them and contact the practice. Remind patient not to wear contacts if they feel unwell of sick.	
Other notes:	
Signature: GOC:	Date: