

PATIENT DATA FORM

Rosani Lens Project | Data Collection Form

DEMOGRAPHICS

DATE OF SERVICE: _____

PATIENT DOB: _____

PATIENT NAME: _____

GENDER (M/F): _____

UNCORRECTED VISUAL ACUITY

RIGHT EYE: _____

LEFT EYE: _____

I-TEST MEASUREMENTS

RIGHT EYE, refractive error: _____ (reading from the I-Test)

RIGHT EYE, visual acuity when looking through I-Test: _____

LEFT EYE, refractive error: _____ (reading from the I-Test)

LEFT EYE, visual acuity when looking through I-Test: _____

CORRECTED VISUAL ACUITY

RIGHT EYE: _____

LEFT EYE: _____

BOTH EYES: _____ (i.e. what is the lowest line on the chart read by the patient with glasses on and both eyes open?)

PATIENT RESPONSE

- Do the new glasses help you to see better?

 - Do you like the new glasses? Will you wear them?

 - In what ways will seeing better with new glasses help in your day-to-day life?

 - How do you plan to care for these glasses?

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