

FAX TO OKLAHOMA MEDICAL EYE GROUP

FAX: 918.747.2056

**DESIRED CORRECTION**

**(TICK AND ENTER REQUIRED TARGET IN BOX)**

**ADDITIONAL NOTES/OBSERVATIONS:**

**DISTANCE**

**INTERMEDIATE**

**NEAR**

**CORRECTED VA**

DIST

**-**

**-**

NEAR

INT

/

x

**NEAR ADD**

**INTERMEDIATE ADD**

**MANIFEST REFRACTION**

DIST

**-**

**-**

NEAR

INT

/

x

**UNCORRECTED VA**

**OD**

**OS**

**Patient Name: DOB:**

**Reason for visit:**

**Referring Doctor: Office Address and Phone:**

**DISTANCE**

**INTERMEDIATE**

**NEAR**

**Light Adjustable Lens (LAL) Refractive Treatment Plan**