Optometrist Co-Management Form

Patient Information

Date D D | M M | Y Y

Patient Name L A S T | F I R S T

AHC Number

Date of Birth D D | M M | Y Y

Email

Cell Phone

Referred By

Co-Management By L A S T | F I R S T

Practice Name

Phone

Fax

Email

Comments

○ Please send additional pads

1. Eye Discomfort

a. During a typical day in the past month, how often did your eyes feel discomfort?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

b. When your eyes felt discomfort, how intense was this feeling at the end of the day, within two hours of going to bed?

NEVER	NOT AT ALL INTENSE		VERY INTENSE	
0	1	2	3	4

2. Eye Dryness

a. During a typical day in the past month, how often did your eyes feel dry?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

b. When your eyes felt dry, how intense was this feeling at the end of the day, within two hours of going to bed?

NEVER	NOT AT ALL INTENSE		VERY INTENSE	
0	1	2	3	4

3. Watery Eyes

a. During a typical day in the past month, how often did your eyes look or feel excessively watery?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

PATIENT SCORE 1 a + 1 b + 2 a + 2 b + 3 a = T O T A L

GUIDE BASED ON PATIENT SCORE RESULTS: >15 Severe >11 Moderate >8 Mild

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