AMPLEYE® Scleral GP Evaluation Form

Account #: _____ **Contact Name:** _____
Phone #: _____ **Patient Name:** _____

Baseline Details	OD	OS
HVID		
Corneal Condition		

Lens Details	OD	OS
Sag & Diam		
Settling Time	❑ Trial Fit _____ min ❑ Follow-up Visit _____ hrs	❑ Trial Fit _____ min ❑ Follow-up Visit _____ hrs

Fit Analysis		OD	OS
Central Clearance (CVZ)		_____ um	_____ um
Peripheral Clearance (PCZ)		❑ Sufficient ❑ Touch: Location _____	❑ Sufficient ❑ Touch: Location _____
Limbal Clearance (LLZ)		_____ um	_____ um
Scleral Landing (SLZ)		❑ Blanching: Heel or Toe 360° or Location _____ ❑ Edge Lift/Uptake 360° or Location _____	❑ Blanching: Heel or Toe 360° or Location _____ ❑ Edge Lift/Uptake 360° or Location _____
CLOCK POSITION:	Toric Markers		
	Sag Indicator or Rx lens R/L		
Over Refraction			

ART Optical contact lens, inc. **Consultation**
phone 800.566.8001 • fax 800.421.5991

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