PATIENT:					
DATE O.D.		OBJECTIVE			
DV R 20/ NV R 20/					
L 20/ L 20/ OU 20/ OU 20/					
UNAIDED SRX CL'S	1				
EYE CHECK	RX CHECK				
When did symptoms start?	Problem?				
Pain?1-10	NV DV	ASSESSMENT & F	PLAN		
Itchy? Red? Matter or Discharge?	Describe concerns		[	1	1
Recent injury or exposure to chemicals or irritants?		DIAGNOSIS	PROC. CODE	NEXT VISIT	OD
Flashes of light or spots?				□ 1 WK □ □ 1 YR	
	<u> </u>				
DATE O.D.		OBJECTIVE			
DV R 20/ NV R 20/					
L 20/ L 20/ OU 20/ OU 20/					
OU 20/ OU 20/ UNAIDED SRX CL'S					
EYE CHECK	RX CHECK	1			
When did symptoms start?	Problem?				
Pain? 1-10	NV DV	ASSESSMENT & F	PLAN		
Itchy? Red? Matter or Discharge?	Describe concerns				
Recent injury or exposure to chemicals or irritants?		DIAGNOSIS	PROC. CODE	NEXT VISIT	OD
				01WK 0	
Flashes of light or spots?				1 YR	
DATE O.D.		OBJECTIVE			
DV R 20/ NV R 20/	1				
L 20/ L 20/					
OU 20/ OU 20/ UNAIDED SRX CL'S					
EYE CHECK	RX CHECK	-			
	Problem?				
When did symptoms start?           Pain?	NV	ASSESSMENT & PLAN			
Itchy? Red?	DV Describe concerns				
Matter or Discharge? Recent injury or exposure to chemicals or irritants?		DIAGNOSIS	PROC. CODE	NEXT VISIT	OD
				□ 1 WK □	
Flashes of light or spots?				1 YR	
DATE O.D.		OBJECTIVE			
DV R 20/ NV R 20/					
L 20/ L 20/					
OU 20/ OU 20/					
UNAIDED SRX CL'S EYE CHECK	RX CHECK				
	Problem?				
When did symptoms start?           Pain?	NV				
Itchy? Red?	DV Describe concerns	ASSESSMENT & F			
Matter or Discharge?		DIAGNOSIS	PROC. CODE		OD
Recent injury or exposure to chemicals or irritants?					
Flashes of light or spots?				□ 1 YR	