

EXTENDED OPHTHALMOSCOPY

PATIENT NAME: _____ CHART #: _____

DATE: _____

DILATION: OD OS OU

Time: _____

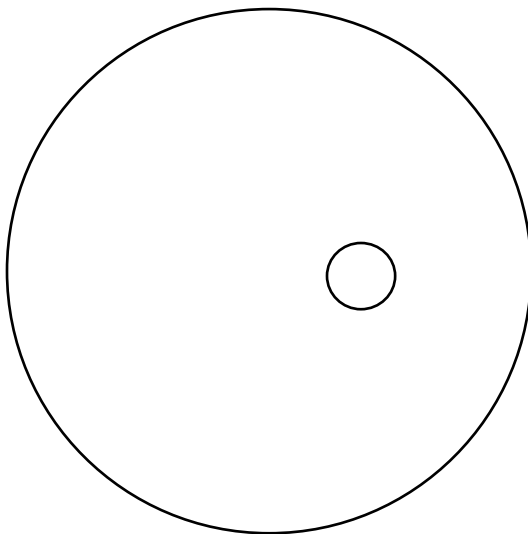
Myd: _____%

Neo: _____%

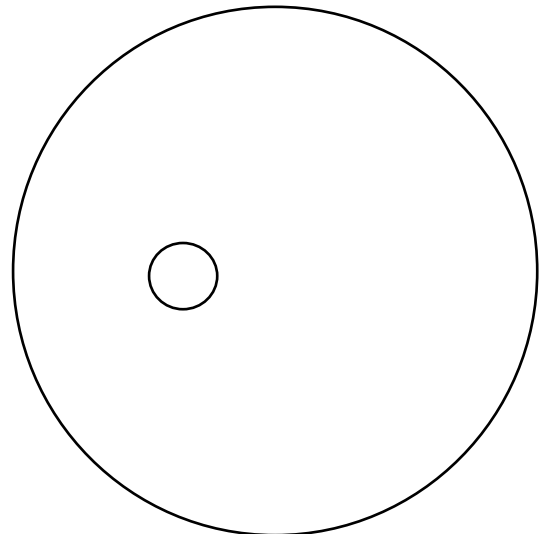
Cyclogyl: _____%

Other: _____%

OD



OS



Lens: 20D, 48D, 78D, 90D, S/D, Contact

IMPRESSION:

PLAN: