Account: ______________ Invoice: ______________ Date: ______________

Patient Name: ______________ Average Wear Time: ______________ Patient Eye Condition: ______________

Jeraly Scleral Fitting Check List

OD LENS	OS LENS

Step 1) INITIAL LENS SELECTION

OD LENS	OS LENS
☐ Base Curve/Power ________	☐ Base Curve/Power ________
☐ Jeraly Lens No. ________	☐ Jeraly Lens No. ________

Step 2) LENS INSERTION & STABILIZATION

OD LENS	OS LENS
☐ Inserted @ ________ AM/PM	☐ Inserted @ ________ AM/PM
☐ Bubbles Y/N	☐ Bubbles Y/N

(Allow Lens to Stabalize for a minimum of 30 min.)

Step 3a) EVALUATE CORNEA APICAL CLEARANCE

OD LENS	OS LENS
☐ Centration ________	☐ Centration ________
☐ Initial Central Clearance ________	☐ Initial Central Clearance ________
☐ Ant Seg Scans @ ________ AM/PM	☐ Ant Seg Scans @ ________ AM/PM
☐ Clearance (Slit Lamp or CT):	☐ Clearance (Slit Lamp or CT):
☐ Superior ________	☐ Superior ________
☐ Central ________	☐ Central ________
☐ Inferior ________	☐ Inferior ________

Step 3b) EVALUATE LIMBAL CLEARANCE

OD LENS	OS LENS
☐ Limbal Clearance ________	☐ Limbal Clearance ________

Step 3c) EVALUATE PERIPHERAL / SCLERAL FIT

OD LENS	OS LENS
☐ Laser Etch Mark Locations ________	☐ Laser Etch Mark Locations ________
☐ Conj Blanching ________	☐ Conj Blanching ________
☐ Micro Bubbles ________	☐ Micro Bubbles ________

Step 4) FINAL POWER

OD LENS	OS LENS
☐ SOR __ 20/ ______	☐ SOR __ 20/ ______

Final Step) ADJUSTMENTS

OD LENS	OS LENS
☐ Comfort ________	☐ Comfort ________
☐ Upon Lens Removal ________	☐ Upon Lens Removal ________
☐ VA 2D/ ________	☐ VA 2D/ ________

VISIONARY
info@visionarylens.com
800-488-2020