KERASOFT® IC

Dynamic Assessment Form

Please ensure all shaded areas are completed and any additional information is entered into the Comments area.

For Movement/Rotation/Centration/Comfort/Visual Acuity, please circle the relevant text.

Patient Name/Ref: _____

Account No: _____

Date: _____

Right Eye/Left Eye

Diagnostic Lens Parameters:					**Order No:**		
		Straight Ahead Gaze			**Upward Gaze**		
Mo	**Movement**	<1.0mm	1.0mm-2.0mm	>2.0mm	<1.0mm	1.0mm-2.0mm	>2.0mm
Ro	**Rotation**	Amount :____°	Clockwise	Counter-clockwise	Amount: ____°	Clockwise	Counter-clockwise
		Stable	Limited Swing	Erratic Swing	Stable	Limited Swing	Erratic Swing
C	**Centration (FOZ Position)**	Central	Decentered Inferior Superior		Central	Drops to Limbus	Drops below Limbus

Co	**Comfort**	Comfortable	Aware in 1 position	General Awareness	Other
VA	**Visual Acuity Over Rx**	VA: _____	No Fluctuation After Blink	Clearer After Blink	Worse After Blink
Over-Refraction (with Vertex Distance):					
Ordered Lens Parameters:					
Comments:					

Right Eye/Left Eye

Diagnostic Lens Parameters:					**Order No:**		
		Straight Ahead Gaze			**Upward Gaze**		
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		Stable	Limited Swing	Erratic Swing	Stable	Limited Swing	Erratic Swing
C	**Centration (FOZ Position)**	Central	Decentered Inferior Superior		Central	Drops to Limbus	Drops below Limbus

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VA	**Visual Acuity Over Rx**	VA: _____	No Fluctuation After Blink	Clearer After Blink	Worse After Blink
Over-Refraction (with Vertex Distance):					
Ordered Lens Parameters:					
Comments:					

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