

Optical Treatment Plan

Patient Name: _____

Date: _____

Work/Occupation

- Computer Glasses
- Safety Glasses
- Driving Glasses
- Reading Glasses

Lenses:

- Single Vision
- Lined Bifocal
- Double Seg (Top+Bottom)
- Lined Trifocal
- No Line Multifocal (Progressive)
Specify _____
- Computer

Lens Enhancements:

- Anti-Reflective
- Transitions
- Polarized
- Tint; Specify _____

Notes: _____

UV Sun Protection

Activities:

Lenses:

- Single Vision
- Lined Bifocal
- Lined Trifocal
- No Line Multifocal (Progressive)
Specify _____

Lens Enhancements:

- Anti-Reflective
- Transitions
- Polarized
- Tint; Specify _____

Notes: _____

Everyday/Backup

Lenses:

- Single Vision
- Lined Bifocal
- Double Seg(Top+Bottom)
- Lined Trifocal
- No Line Multifocal (Progressive)
Specify _____

Lens Enhancements:

- Anti-Reflective
- Transitions
- Polarized
- Tint; Specify _____

Notes: _____

Other Prescribed Solutions

- Dry Eye
- Myopia Management
- IPL
- Supplements
- Contact Lenses

Notes: _____
