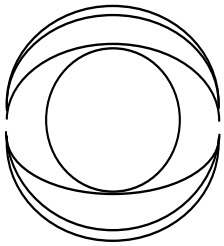
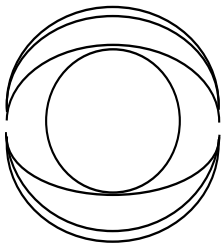
EYE CENTER OF TEXAS LATISSE® CONSULTATION

PATIENT NAME:_____ **TECH:**_____

OD



OS



	OD		OS
L/L	☐	**WNL**	☐
	☐	BLEPH	☐
CONJ	☐	**W&Q**	☐
	☐	N T PING N T	☐
CORNEA	☐	**CLEAR**	☐
	☐	N T PTERYG N T	☐
A/C	☐	**D &Q**	☐
	☐	_____ + C&F _____ + C&F	☐
IRIS	☐	**WNL**	☐

- ☐ **Discussed possible side effects of Latisse to include eyelid darkening, eyelid margin redness and conjunctival redness.**
- ☐ **Iris pigmentation changes seen only in 1.5% of patients with use in the eye for glaucoma treatment. NOT SEEN WITH PROPER USE OF LATISSE.**
- ☐ **Discussed proper usage of medication including one applicator per eye per usage, one drop per applicator, upper eyelid margin only, blot excess.**
- ☐ **Do not use if pregnant, nursing, or attempting pregnancy.**
- ☐ **Patient aware takes 8-12 weeks for full effect.**
- ☐ **Photos done.**
- ☐ **Written instructions given.**
- ☐ **Patient aware medical eye exam not performed.**
- ☐ **Referral to area optometrist provided prn. Dr. _____**

PATIENT INITIAL

_____

- □ **Latisse candidate.**
  - □ **Prescription written with 2 refills. Return visit 3 months. If appropriate a one year prescription will be given at follow-up.**
  - □ **Patient established on product. One year prescription given.**
- □ **Not a Latisse candidate due to _____.**

RETURN VISIT IN:	**Signature**	**Date of Service:**
FOR:		Faxed: By:

DO NOT WRITE BELOW THIS LINE