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| C:\Users\yumang\AppData\Local\Temp\1\Temp1_RGB-screen.zip\RGB (screen)\JPG\CEI-1CBLACK-POS.jpg**Oregon Health & Science University**  **Casey Eye Institute – Ultrasound Service**  **Biometry Request**  Please fax to number below  *P: 503-494-6795 F: 503-494-5188*  Page 1 of 1 | NAME Click or tap here to enter text.  BIRTHDATE Click or tap here to enter text.  *Patient Identification* |
| **Biometry:** Choose an item.  **Lens Status:**   |  |  | | --- | --- | | OD- Choose an item. | OS- Choose an item. |   **Vitreous Status:**   |  |  | | --- | --- | | OD- Choose an item. | OS- Choose an item. |   **Refractive Surgery:**   |  |  | | --- | --- | | OD- Choose an item. | OS- Choose an item. |   **Refractive Target:**   |  |  | | --- | --- | | OD- Click or tap here to enter text. | OS- Click or tap here to enter text. |   **Formula:** Choose an item.  **Lens** (manufacturer, model)**:** Click or tap here to enter text.  **COMMENTS:**  Click or tap here to enter text. | |

\*If IOL master is unable to measure axial length, immersion A-scan will be performed.

\*Not all lenses are available

\*Recalculations must be done by referring physician