
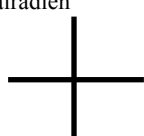
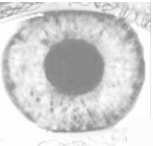
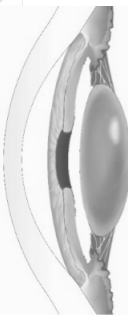
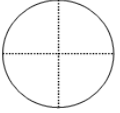
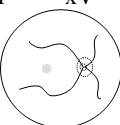


Motivation für KL AP:								derzeitige Korrektur:							
Erwartungen an KL:															
Gewünschte Tragedauer:															
Letzte Augenuntersuchung Wann:				Wo:											
Okuläre Gesundheit:				Okuläre Symptome:											
Augenerkrankungen:				Allgemeinerkrankungen:											
Medikation: <input type="checkbox"/> nein <input type="checkbox"/> ja:				Allergien auf Medikamente:											
Umweltallergien:				Familienhistorie:											
Vsc	bisher HSA:	sph	cyl	A	add	V	Subj. HSA:	sph	cyl	A	add	Vcc	Vcc bin	Führung sensor.	Cover
	R						R								F:
	L						L								N:
	PERRLA	RAPD	IOD Zeit:		MEM Skia	NPC		Motilität:				Sonstiges:			
R	<input type="checkbox"/>	<input type="checkbox"/> ja <input type="checkbox"/> nein													
L	<input type="checkbox"/>	<input type="checkbox"/> ja <input type="checkbox"/> nein													

<b>R</b>	 <p>Zentralradien</p>  <p>ε</p> <p>HH Ø : _____ mm</p>  	<p>Höhe _____ <input type="checkbox"/>glatt <input type="checkbox"/>unregelmäßig TBUT _____ Sek. <input type="checkbox"/>sonst.:</p> <p><input type="checkbox"/>normal <input type="checkbox"/>sonst.: <input type="checkbox"/>unvollständig</p> <p><input type="checkbox"/>normal <input type="checkbox"/>Kosmetikablagerung <input type="checkbox"/>Schaumbildung <input type="checkbox"/>sonst.:</p> <p><input type="checkbox"/>normal <input type="checkbox"/>Hyperämie: <input type="checkbox"/>Pinguecula <input type="checkbox"/>LIPCOF: <input type="checkbox"/>sonst.:</p> <p><input type="checkbox"/>normal <input type="checkbox"/>Hyperämie: <input type="checkbox"/>sonst.:</p> <p><input type="checkbox"/>klar <input type="checkbox"/>Trübung: <input type="checkbox"/>Stippen <input type="checkbox"/>sonst.:</p> <p><input type="checkbox"/>normal <input type="checkbox"/>sonst.:</p> <p><input type="checkbox"/>normal <input type="checkbox"/>neovas.:</p> <p><input type="checkbox"/>sonst.:</p> <p><input type="checkbox"/>normal <input type="checkbox"/>sonst.:</p> <p>Van Herick: T _____ :1 N _____ :1</p> <p><input type="checkbox"/>normal <input type="checkbox"/>sonst.:</p> <p><input type="checkbox"/>normal <input type="checkbox"/>Trübung: <input type="checkbox"/>sonst.:</p> <p><input type="checkbox"/>normal <input type="checkbox"/>sonst.:</p>	<p><b>TM Tränenfilm</b></p> <p>Höhe _____ <input type="checkbox"/>glatt <input type="checkbox"/>unregelmäßig TBUT _____ Sek. <input type="checkbox"/>sonst.:</p> <p><b>Lid Lidschluss</b></p> <p><input type="checkbox"/>normal <input type="checkbox"/>sonst.: <input type="checkbox"/>unvollständig</p> <p><b>Lidrand</b></p> <p><input type="checkbox"/>normal <input type="checkbox"/>Kosmetikablagerung <input type="checkbox"/>Schaumbildung <input type="checkbox"/>sonst.:</p> <p><b>Conj. bulbär</b></p> <p><input type="checkbox"/>normal <input type="checkbox"/>Hyperämie: <input type="checkbox"/>Pinguecula <input type="checkbox"/>LIPCOF: <input type="checkbox"/>sonst.:</p> <p><b>Conj. tarsal</b></p> <p><input type="checkbox"/>normal <input type="checkbox"/>Hyperämie: <input type="checkbox"/>sonst.:</p> <p><b>Cornea Endothel</b></p> <p><input type="checkbox"/>klar <input type="checkbox"/>Trübung: <input type="checkbox"/>Stippen <input type="checkbox"/>sonst.:</p> <p><input type="checkbox"/>normal <input type="checkbox"/>sonst.:</p> <p><b>Limbus</b></p> <p><input type="checkbox"/>normal <input type="checkbox"/>neovas.:</p> <p><input type="checkbox"/>sonst.:</p> <p><b>VK</b></p> <p><input type="checkbox"/>normal <input type="checkbox"/>sonst.:</p> <p>Van Herick: T _____ :1 N _____ :1</p> <p><b>Iris</b></p> <p><input type="checkbox"/>normal <input type="checkbox"/>sonst.:</p> <p><b>Linse</b></p> <p><input type="checkbox"/>normal <input type="checkbox"/>Trübung: <input type="checkbox"/>sonst.:</p> <p><b>Vitreous</b></p> <p><input type="checkbox"/>normal <input type="checkbox"/>sonst.:</p>	<b>L</b>
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<b>R</b>	 <p>Form:</p> <p>C/D:H _____ xV</p> 	<p>Scharf begrenzt: <input type="checkbox"/>ja <input type="checkbox"/>nein vital: <input type="checkbox"/>ja <input type="checkbox"/>nein ISNT: <input type="checkbox"/>ja <input type="checkbox"/>nein <input type="checkbox"/>grenzwertig Lamina: <input type="checkbox"/>ja <input type="checkbox"/>nein Exkavation: <input type="checkbox"/>flach <input type="checkbox"/>normal <input type="checkbox"/>tief <input type="checkbox"/>sonst.:</p> <p>Reflex: <input type="checkbox"/>ja <input type="checkbox"/>nein Makula Pigmentierung: <input type="checkbox"/>normal <input type="checkbox"/>abnormal <input type="checkbox"/>sonst.:</p>	<p><b>Papille</b></p> <p>R <input type="checkbox"/>bin. <input type="checkbox"/>mon.</p> <p>L <input type="checkbox"/>bin. <input type="checkbox"/>mon.</p> <p><b>Makula</b></p> <p>Reflex: <input type="checkbox"/>ja <input type="checkbox"/>nein Makula Pigmentierung: <input type="checkbox"/>normal <input type="checkbox"/>abnormal <input type="checkbox"/>sonst.:</p>	<b>L</b>
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<b>Feststellungen</b>	<b>Management/Plan</b>																									
		<table border="1" style="margin: auto;"> <tr> <td></td> <td>sph</td> <td>cyl</td> <td>A</td> <td>add</td> <td>r</td> <td>Ø</td> <td></td> </tr> <tr> <td><b>R</b></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>L</b></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		sph	cyl	A	add	r	Ø		<b>R</b>								<b>L</b>							
	sph	cyl	A	add	r	Ø																				
<b>R</b>																										
<b>L</b>																										
		<p><b>KL:</b></p> <p><input type="checkbox"/>F <input type="checkbox"/>N <input type="checkbox"/>Monov.: _____ <input type="checkbox"/>Multi: _____</p>																								
	Pflegemittel: <input type="checkbox"/> Handhabung:																									