Treehouse Eyes Myopia Treatment Co-Management Form

Patient: _____ DOB: _____ Gender: M / F

Parent's Name: _____

Parent's Preferred Contact Method:
□ Email: _____ □ Phone: _____

The patient's parents have had their questions answered regarding the consequences of treating versus not treating their child's myopia (for example, possible eye health implications of increasing myopia). □ Yes □ No

Ethnicity: □ Asian □ Black □ Latino □ Caucasian □ Other: _____

Patient has been myopic for approximately ___ years

Parents Myopic: □ Yes □ No Who: □ Mother □ Father
Siblings Myopic: □ Yes □ No How many myopic siblings: _____

VAsc: OD: 20/_____ OS: 20/_____

Current Subj Rx: OD: _____ 20/ OS: _____ 20/

Previous Rx: (Date: _____)
OD: _____20/ OS:_____20/

Estimated digital device use: _____hrs/day Estimated time outdoors: _____hrs/day

Referring Doctor: _____ Doctor's email: _____

Will you be co-managing: □ Yes □ No

INSIGHT VISION CENTER OPTOMETRY

Treehouse Eyes
MYOPIA CARE FOR KIDS

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