ALCON IOL POWER CALCULATION CONSULT FORM

This form is being sent in response to your unsolicited request for support with IOL calculations. Should you have any questions or need assistance in completing this form, please contact Alcon Medical Information Services at **800.757.9785**.

Alcon IOL Power Calculation Assistance Policy:

Alcon performs intraocular lens (IOL) power calculations in response to unsolicited requests for assistance from surgeons using Alcon IOLs. This service is provided as a courtesy to Alcon customers and requests for IOL calculations will only be accepted for Alcon products. In order to help determine an accurate calculation, it may be necessary for Alcon to contact the requesting surgeon for confirmation of submitted information and/or additional data to support the request. Alcon may decline calculation services for lack of sufficient reliable data or for misuse of these services.

Calculation services require a minimum of two business days after all required data have been received for non-post-refractive ReSTOR and Toric IOL model requests; "rush" or immediate services are not available.

Calculation services for all other models and for post-refractive IOL requests are not available at this time.

Please circle one: Accept Terms Decline Terms

Surgeon Name ________________________________ **Today's Date** ________/__________/__________

Phone#_______________________________________ __ **Fax#**____________________________________

Email Address:__________________________________ **Account #**________________________________

Surgeon Attestation:

I, as the operating surgeon, attest that the data and information provided herein are true and accurate. I request that Alcon provide me with calculation confirmation using the Holladay 2 formula to assist me in making a decision regarding intraocular lens power selection. I acknowledge that Alcon's service is dependent on the accuracy of my data. I understand that Alcon does not intend to provide medical or surgical advice, does not warrant or guarantee the accuracy or completeness of this information and disclaims any liability for unanticipated refractive or surgical outcomes. I release Alcon from any liability for this service. I further acknowledge that the selection of the specific intraocular lens model, A-constant and power used for this patient is solely my responsibility as the operating surgeon.

Surgeon Initials: __________

Patient Details

Patient Age ___________ **Patient ID**________________________ **Gender**: ☐**M** ☐**F**

Calculation Assistance Requested for: ☐**OD** ☐**OS** ☐**OU**

Date of Surgery: OD_______/________/________ **OS**_______/_________/________

FOR VALIDATION PURPOSES, PLEASE PROVIDE RELEVANT DATA FOR BOTH EYES EVEN IF REQUEST IS ONLY FOR ONE EYE.

FAX COMPLETED FORM TO ALCON AT 800.757.9786 or EMAIL to medinfo@alconlabs.com

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Surgeon Name ______________________ **Fax#** __________________ **Patient ID**________________

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OD

Preoperative Data

Pre-Operative Refraction: ________ ________ x ________ ☐ **Pre-Cataract "Most Plus" (Preferred)** ☐ **Current**

Horiz White to White _________mm **Phakic Lens Thickness** (**rec.** for AL < 22.0mm) _________mm

K1_________D @________ **K2**__________D @________ **Method for Ks:**____________________

Axial Length _________mm **Phakic ACD** ________mm

Method used for Axial Length: ☐ **Contact** ☐ **Immersion** ☐ **IOLMaster / LENSTAR**

Does the patient have a history of any of the following:

Keratoconus: ☐ **Yes** ☐ **No** **Scleral Buckle:** ☐ **Yes** ☐ **No** **Silicone Oil:** ☐ **Yes** ☐ **No**

Other Ocular Pathology: ☐ **Yes** ☐ **No** If yes, please explain:_________________________

Keratorefractive Surgery: ☐ **Yes** ☐ **No** If yes, please explain:_________________________

Surgical Plan

Alcon Lens Model ____________ **Lens Constant** ___________ **Optimized ?** ☐ **Yes** ☐ **No**

Target Ref _________D **IOL Power** _________D **Formula Used**_______________

OS

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CALCULATION WILL INCLUDE HOLLADAY 2 FORMULA ONLY

All data points may be required to process calculation

Comments:____

****REQUIRED****

SURGEON SIGNATURE:

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