VeoOphthalmics

CUSTOM*FLEX*® ARTIFICIAL*IRIS* ORDER FORM

FROM: *(Surgeon Contact Information)*	
Surgeon Name	
Company	
Contact Name	
Street	
City/State	
Zip code	
Phone	
Email	

TO: *(VEO Use Only)*	
Name	VEO Ophthalmics
Contact	Sidney Christensen
Address	10184 International Blvd. West Chester, OH 45246
Phone	(513) 872-1330
Fax	(513) 961-2858
Email	schristensen@veo-ophthalmics.com
Customer ID	
Invoice #	

PATIENT INFORMATION:

Patient's Name: First_____Middle_____Last _____

MODEL SELECTION:

RIGHT EYE: ☐ **N/A** ☐ **LEFT EYE:** ☐ **N/A** ☐

☐ **CUSTOM*FLEX*® ARTIFICIAL*IRIS* With Fiber**	☐ **CUSTOM*FLEX*® ARTIFICIAL*IRIS* With Fiber**
☐ **CUSTOM*FLEX*® ARTIFICIAL*IRIS* Fiber Free**	☐ **CUSTOM*FLEX*® ARTIFICIAL*IRIS* Fiber Free**

COLOR TEMPLATE: A photo printout (hard copy) must be included with the order form to provide a color template for the production of the CUSTOM*FLEX*® ARTIFICIAL*IRIS*. Please submit the patient's 3 photos (right eye, left eye, bridge with both eyes), and label which single eye photo should be used as a template for production. For congenital aniridics, submit a 4th photo to use as the template. If implantation in both eyes is planned, it is recommended that the devices for both eyes be ordered at the same time to provide the best color match. Refer to the photo directives for photo requirements.

☐ Attach a photo printout of the right eye, left eye and bridge to this order form. The patient's initials and eye (OD, OS and Bridge) must be recorded on each photo printout submitted.

☐ **ONLY** the production template photo printout must be signed and dated by the surgeon and the patient.

☐ Send the completed artificial iris order form and photo printouts to VEO Ophthalmics for processing.

PAYMENT INFORMATION ***U.S. Federal law restricts this device to sale by or on the order of a physician. U.S. Federal law restricts this device to practitioners who have been trained and have experience in the surgical management and treatment of aniridia.**

Device cost includes 2 devices, 1 primary and 1 backup. If the backup device is not returned to VEO Ophthalmics, or otherwise accounted for, you will be invoiced for the full charge of the backup device. Check, credit card, or PO is accepted. Please make checks payable to **VEO Ophthalmics** and add the patient's initials to the check memo or PO.

Check or PO#_____(Required)

Payer Type, please advise:

☐ **Medicare Part B** ☐ **Medicare Part C:** _____ ☐ **Commercial Ins.:** _____ ☐ **Other:**

Surgeon Signature:_____ Date: _____

*** The manufacturer is not liable for a postoperative difference in color between natural iris tissue and the iris implant. In case of a cancellation of this custom-made medical device after production has been initiated, a refund or credit is not possible.**