NORTH TORONTO EYE CARE
NORTH TORONTO EYE SURGERY CENTRE

2065 Finch Ave W, North York, ON M3N 2V7
7 Elmwood Ave, North York, ON M3N 2V7
2 Champagne Dr Unit C2, Toronto, ON M3J 0K2

YOUR NORTH TORONTO EYE CARE DRY EYE CLINIC

DRY EYE TREATMENT PLAN

Name **Date** **DOB**

SPEED QUESTIONAIRRE

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

Report the type of SYMPTOMS you experience and when they occur:

	At this visit		Within the past 72 hours		Within the past 3 months	
Symptom	YES	NO	YES	NO	YES	NOT
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

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Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

Report the SEVERITY of your symptoms using the rating list below:

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable - irritating, but does not interfere with my day
3 = Bothersome - irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

Do you use eye drops for lubrication? (Circle)

YES	NO	If YES, please indicate drop and frequency of use.

FOR OFFICE USE ONLY	Total SPEED score (Frequency + Severity) = ____/28

drs@northtorontoeyecare.com

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CUSTOMIZED TREATMENT PLAN:

<table>
<tr><td>ESSENTIAL THERAPIES</td><td colspan="4">✓ Lifestyle Modification
✓ Lubricating eye drops: _____times per day & as needed.
✓ Hot compresses: _____ times per day for _____minutes / time
✓ Lid wipes: _____times per day.
✓ Omega 3 supplements _____ capsules / day
✓ Other:</td></tr>
<tr><td>INTERMEDIATE THERAPIES
+BASIC</td><td colspan="4">Additional medication: (if drops, use 1 drop each time)
_____ _____times per day x _____weeks
_____ _____times per day x _____weeks
_____ _____times per day x _____weeks
_____ Zest Treatment</td></tr>
<tr><td rowspan="2">ADVANCED THERAPIES
+ BASIC
+
INTERMEDIATE</td><td>AQUEOUS DEFICIENT DRY EYE</td><td colspan="3">EVAPORATIVE DRY EYE</td></tr>
<tr><td>○ Restasis or Xiidra
○ Punctal plugs.
○ Autologous serum eye drop.</td><td>Eyelid Inflammation</td><td>Meibomian Gland Obstruction</td><td>Significant Obstruction & Inflammation</td></tr>
<tr><td colspan="2"></td><td>IPL Therapy*</td><td>Thermal Pulsation</td><td>IPL Therapy*
+
Thermal Pulsation</td></tr>
</table>

*IPL is only suitable for certain skin types

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