IOL FOLLOW-UP

Cataract and Eye Consultants
Phone 724-617-2020 • Fax 724-453-4108

PATIENT NAME _____ REFERRING DOCTOR _____

DATE OF BIRTH _____ DATE OF EXAM _____

_____ DAY / WEEK / MONTH S/P IOL OD

STD / LRI / TORIC / MF / _____

_____ DAY / WEEK / MONTH S/P IOL OS

STD / LRI / TORIC / MF / _____

OD:

UCVA: _____

REF: _____ 20/_____

IOP: _____

CORNEA

AC/IRIS

LENS IN GOOD POSITION? Y / N

DILATION? Y / N

FUNDUS:

OS:

UCVA: _____

REF: _____ 20/_____

IOP: _____

CORNEA

AC/IRIS

LENS IN GOOD POSITION? Y / N

DILATION? Y / N

FUNDUS:

If VA is less than 20/30, please explain: _____

PATIENT SATISFACTION: [ ] Very Happy [ ] Satisfied [ ] Dissatisfied

ASSESSMENT: _____

_____

PLAN: _____

_____

_____ Report Faxed to CEC Signature _____