Post-Operative Exam
ICL

Patient Information

name

dob (mm/dd/year) phone

date of procedure

date of this exam

Referring Information

practice name

referring doctor

office phone/fax

office contact

Procedure Performed — Visian ICL — Eye(s) Treated OD OS OU

Medications & Comments

Clinical Findings: OU Dist 20/______ Near 20/______

UCVA OD Dist 20/______ Near 20/______ OS Dist 20/______ Near 20/______

	OD	OS
Manifest Refraction	______________________________20/______	______________________________20/______
IOP	______ mmHG	______ mmHG
Lens Vault	______	______

Assessment & Plan

doctor signature

date

Please contact us by telephone if you require assistance with any post-operative condition. O 405.842.6060 F 405.842.6130

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