Post-Operative Exam

Cataract Surgery

Patient Information

name

dob (mm/dd/year) phone

date of this exam

date of procedure: OD / OS

Referring Information

practice name

referring doctor

office phone/fax

office contact

Procedure Performed
OD: Femto / Non-Femto / Crystalens / Toric / Multifocal / Monofocal / Monovision
OS: Femto / Non-Femto / Crystalens / Toric / Multifocal / Monofocal / Monovision

Medications & Comments

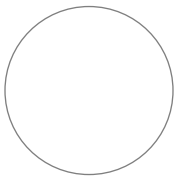
Clinical Findings

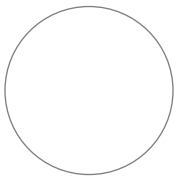
UCVA OD 20/_____ OS 20/ _____ OU 20/_____

Near VA OD 20/J_____ Near VA OD 20/J_____ OU 20/J _____

Manifest Refraction OD _____20/_____ OS _____20/_____

Cycloplegic Refraction OD _____20/_____ OS _____20/_____





Lens Position: OD _____ IOP _____ OS _____ IOP _____

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