Post-Operative Exam
ICL (Implantable Collamer Lens)

Patient Information	Referring Information
name	practice name
dob (mm/dd/year) phone	referring doctor
date of procedure	office phone/fax
date of this exam	office contact

Procedure Performed: EVO ICL / EVO TORIC ICL

Eye(s) Treated: OD OS OU

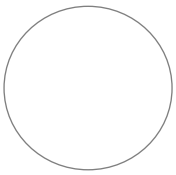
Medications & Comments

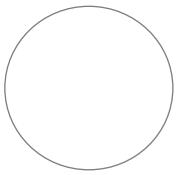
Clinical Findings:

OU Dist 20/_____ Near 20/_____ Target **OD** Plano / Mono **OS** Plano / Mono

UCVA **OD** Dist 20/_____ Near 20/_____ **OS** Dist 20/_____ Near 20/_____

Manifest Refraction	_____20/_____	_____20/_____
IOP	_____ mmHG ADD _____ 20/_____	_____ mmHG ADD _____ 20/_____





Lens Vault: **OD** _____ **OS** _____

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

V20231019/ss