LASER VISION LONDON

CATARACT/RLE/ICL POST-OPERATIVE FORM

Tel: 519-204-7777 • Fax: 519-204-1010

Name _____ **Phone** _____ **D.O.B.** _____ **Tx:** ○ CATARACT ○ RLE ○ ICL

Co-Managing Doctor _____ **Doctor Phone** _____ **Doctor Fax** _____ **IOL Type** ☐ Monofocal ○ OD ○ OS

☐ Multifocal ○ OD ○ OS

☐ Toric ○ OD ○ OS

☐ ICL ○ OD ○ OS

Doctor Email _____ **Surgery Date** _____

Meds/Dosage: ○ Prolensa_____ ○ Zymar_____ ○ Pred Forte_____ ○ Maxidex_____ ○ Artificial Tears_____

OD Target: ○ Plano ○ Other _____ **OS Target:** ○ Plano ○ Other _____

	OD	OS
UCDVA	**20 /**	**20 /**
UCNVA	**20 /**	**20 /**
For Multi IOLs UIVA	**20 /**	**20 /**
Refraction	_____ **20 /**	_____ **20 /**
Post Op K Reading (for all Multi & Toric IOLs)	_____ / _____ @ _____	_____ / _____ @ _____
SLIT LAMP	Wound: ☐ Intact _____ Cornea: ☐ Clear _____ AC: ☐ Deep ☐ Quiet _____ IOL: ☐ Good Position _____ Post Segment: ☐ Normal _____	Wound: ☐ Intact _____ Cornea: ☐ Clear _____ AC: ☐ Deep ☐ Quiet _____ IOL: ☐ Good Position _____ Post Segment: ☐ Normal _____
IOP	_____ **mmHg**	_____ **mmHg**

Next followup visit scheduled: _____ ○ day ○ week ○ month ○ year **Follow up required with LVL?** ○ Y ○ N

Doctor's Comments/Treatment: ○ excellent ○ stable ○ enhancement _____

Quality of Vision: ○ Excellent ○ Acceptable ○ Poor (if poor, please comment) _____

Patient Satisfaction: ○ Satisfied ○ Not Satisfied (if not satisifed, please comment) _____

Comments _____

_____

Dr. Signature _____ **Date** _____