



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

Co-Managing Dr. _____ Dr. Phone _____ Dr. Fax _____ IOL Type: Monofocal OD OS

Dr. Email _____ Surgery Date _____ Multifocal OD OS

Med: / Dosage: Prolensa _____ Vigamox _____ Maxidex _____ Toric OD OS

Artificial Tears: _____ ICL OD OS

OD Target: Plano Other _____ OS Target: Plano Other _____

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 satisfied, please comment) _____

Comments _____

Dr. Signature _____ Date _____