Post Op Cataract Assessment Report

Procedure: ◯ Monofocal ◯ Toric IOL ◯ Multifocal

Patient Information

Name ______________________ Date ______________ DOB ____/____/____

Surgeon ______________________ Co-Managing Doctor ______________________

◯ Right Eye ◯ Left Eye ◯ Both Eyes ◯ This Visit ________ Days ◯ Week ◯ 1 Month

Vision Assessment

Uncorrected Vision: OD 20/ OS 20/

Best Corrected Vision: OD 20/ OS 20/

Manifest Refraction: OD ______________________ OS ______________________

Exam

I.O.P Reading: OD ______________________ OS ______________________

Slit Lamp: OD ______________________

OS ______________________

Ocular Medication (After this Visit) Please indicate dosage:

Meds	Pred Forte	Ocuflox	Ketorolac
Right Eye			
Left Eye			

Comments ______________________

____

Examining Doctor ______________________ Date ______________

Signature ______________________ Please Fax to: 231-733-0566