Post Op Clear Lens Exchange Assessment Report

Procedure: ◯ Monofocal ◯ Toric IOL ◯ ReSTOR IOL ◯ CrystaLens IOL

Patient Information

Name _____ Date _____ DOB ____/____/____

Surgeon _____ Co-Managing Doctor _____

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

Vision Assestment

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	Zymar	Acular LS
Right Eye			
Left Eye			

Comments _____

_____

Examining Doctor _____ Date _____

Signature _____ Please Fax to: 231-733-0566

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