CATARACT AND LASER INSTITUTE

Laser Vision Correction Quality Assurance Post-op Report

Thank you for sharing the following details of your exam findings.

Patient's name _____

Date of birth _____

Examining doctor _____

Date of exam _____

Date of surgery _____

Surgery ☐ LASIK ☐ PRK

Exam Interval
☐ 1 day
☐ 1 month for LASIK
☐ 3-6 months for PRK

RIGHT EYE

Manifest refraction _____ - _____ x _____ 20/_____

LEFT EYE

Manifest refraction _____ - _____ x _____ 20/ _____

How do you rate this patient's satisfaction?

☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very dissatisfied

Comments or pertinent findings _____

_____

_____

Your patient's lifetime enhancement policy depends on us receiving 1-month post-op findings for LASIK or 3 to 6-month findings for PRK.

Kindly fax to (360) 807-7689 or mail to PCLI, 2517 NE Kresky Ave, Chehalis, WA 98532