CATARACT AND LASER INSTITUTE

Cataract Surgery Quality Assurance 4-6 Week Post-op Report

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

Patient's name _____ Date of surgery _____

Patient's DOB _____ Date of exam _____

Examining doctor _____

RIGHT EYE

Refraction _____ - _____ x _____ 20/_____

LEFT EYE

Refraction _____ - _____ x _____ 20/_____

How do you rate this patient's satisfaction?

☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very Dissatisfied

Comments _____

_____

_____

Fax to (406) 452-1020 or mail to PCLI, 1621 Market Place Drive, Great Falls, MT 59404