



## 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

### LEFT EYE

Refraction \_\_\_\_\_ - \_\_\_\_\_ x \_\_\_\_\_ 20/ \_\_\_\_\_      Refraction \_\_\_\_\_ - \_\_\_\_\_ x \_\_\_\_\_ 20/ \_\_\_\_\_

How do you rate this patient's satisfaction?

Very Satisfied      Satisfied      Neutral      Dissatisfied      Very Dissatisfied

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fax to (253) 473-0706 or mail to PCLI, 2915 S. Alder Street, Tacoma, WA 98409