



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