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 ____

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Fax to (509) 966-5101 or mail to PCLI, 3900 Kern Road, Yakima, WA 98902