PCLI
CATARACT AND LASER INSTITUTE

First Eye Lens Implant Feedback

CATARACT 5 TO 10 DAY POST-OP FINDINGS

Patient's Name ____________________

Date of Birth ____________________

Date of Surgery ____________________

Examining Doctor ____________________

Date of Exam ____________________

Right Eye

Uncorrected VA 20/ ________

Refraction ________ - ________ x ________ 20/ ________

Left Eye

Uncorrected VA 20/ ________

Refraction ________ - ________ x ________ 20/ ________

How do you rate this patient's satisfaction with their refractive error outcome?

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

Comments ____________________

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KINDLY FAX TO PCLI

Thank you in advance for sharing findings from your cataract 5 to 10 day post-op exam. The details you provide on this patient's first eye surgery will help us plan for treatment on the second eye and optimize their refractive outcome.

Fax to the following office:

- ☐ Anchorage, AK (907) 272-2428
- ☐ Boise, ID (208) 385-0050
- ☐ Lewiston, ID (208) 746-0413
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