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 _____

_____

_____

_____

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
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