YAG CAPSULOTOMY FOLLOW-UP

SightLine Ophthalmic Associates
Phone 724-933-5588 • Fax 724-933-6051

PATIENT NAME _____ REFERRING DOCTOR _____

DATE OF BIRTH _____ PROCEDURE DATE(S) _____

DATE OF EXAM _____

EYE TREATED ☐ OD ☐ OS

CLINICAL FINDINGS:

BCVA: R _____

L _____

IOP: R _____

L _____

SLIT LAMP: _____

_____

FUNDUS: _____

_____

NOTE ANY ADVERSE EVENTS: _____

_____

_____

PATIENT SATISFACTION: ☐ Very Happy ☐ Satisfied ☐ Dissatisfied

ASSESSMENT: _____

_____

PLAN: _____

_____

_____ Report Faxed to SightLine

Signature _____