IOL 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 ____________________________________ _______ DAY / WEEK / MONTH FOLLOW-UP

OD:

UCVA: _____________

REF: ______________________________ 20/_______

IOP: _____________

CORNEA

AC/IRIS

LENS IN GOOD POSITION? Y / N

DILATION? Y / N

FUNDUS:

OS:

UCVA: _____________

REF: ______________________________ 20/_______

IOP: _____________

CORNEA

AC/IRIS

LENS IN GOOD POSITION? Y / N

DILATION? Y / N

FUNDUS:

If VA is less than 20/30, please explain: ____

PATIENT SATISFACTION: ☐ Very Happy ☐ Satisfied ☐ Dissatisfied

ASSESSMENT: ____

____

PLAN: ____

____

_____ Report Faxed to SightLine

Signature ____