

PROCEDURE FOLLOW-UP

SightLine Ophthalmic Associates

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PATIENT NAME _____

REFERRING DOCTOR _____

DATE OF BIRTH _____

PROCEDURE DATE(S) _____

DATE OF EXAM _____

PROCEDURE SLT YAG CAPSULOTOMY

EYE TREATED OD OS

YAG PI OTHER _____

CLINICAL FINDINGS:

BCVA: R _____

L _____

IOP: R _____

L _____

SLIT LAMP: _____

FUNDUS: _____

NOTE ANY ADVERSE EVENTS: _____

PATIENT SATISFACTION: Very Happy Satisfied Dissatisfied

ASSESSMENT: _____

PLAN: _____

