Diagnostic Eye Center

# 4-6 Week Cataract Post-Op Report

*Please fax your exam findings to **713-797-1150**. Our surgeons rely on this data, and we appreciate your help!*

**Patient Name:** _____ **DOB:** _____

**Operative Eye:** □ OD □ OS **Date of Surgery:** _____ **Date of Exam:** _____

**IOL Used:** _____ **Target Correction:** _____ **Surgeon:** □ Sanders □ Salem

**Uncorrected Distance VA**

OD: 20/_____

OS: 20/_____

**Refraction**

OD: _____ 20/_____

OS: _____ 20/_____

**Uncorrected Near VA** (if premium IOL)

OD: J _____

OS: J _____

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

□ Very Satisfied □ Satisfied □ Neutral □ Dissatisfied □ Very Dissatisfied

**Comments:** _____

_____

**Examining Physician** (print name): _____

**Signature:** _____

*Please contact us by telephone at 713-797-1500 if you need assistance with any post-operative condition.*