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.