YAG CAPSULOTOMY FOLLOW-UP

Cataract and Eye Consultants
Phone 724-617-2020 • Fax 724-453-4108

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 CEC

Signature _____