SPECIALTY EYE INSTITUTE

Cataract Post-op Reporting Form

Patient Name:_____ DOB: _____ Date Of Exam:_____

SURGEON:

☐ Ronald Brown, MD ☐ Luis Gago, MD ☐ James Ravin, MD ☐ Clint Simpson, MD
☐ Mahmoud El-Yassir, MD ☐ Kevin Lavery, MD ☐ Marcus Rhem, MD ☐ Neal Tolchin, MD
☐ Paul Ernest, MD ☐ Sujata Purohit, MD ☐ Anthony Sensoli, MD ☐ RaShawn Venerable, DO

OD

Date of Surgery: _____

Lens:

☐ Monofocal ☐ Toric/Axis @_____
☐ Crystalens ☐ Femto Laser
☐ Symfony ☐ Symfony Toric/Axis @_____
☐ ReStor ☐ ReStor Toric/Axis@_____
☐ PanOptix ☐ PanOptix Toric/Axis@_____
☐ Other:_____

BCVA: 20 / _____

Manifest Refraction: _____

IOP: _____

IOL Status: ☐ Centered / Decentered ☐

Posterior Capsule: ☐ Clear / Cloudy ☐

OS

Date of Surgery: _____

Lens:

☐ Monofocal ☐ Toric/Axis @_____
☐ Crystalens ☐ Femto Laser
☐ Symfony ☐ Symfony Toric/Axis @_____
☐ ReStor ☐ ReStor Toric/Axis@_____
☐ PanOptix ☐ PanOptix Toric/Axis@_____
☐ Other:_____

BCVA: 20 / _____

Manifest Refraction: _____

IOP: _____

IOL Status: ☐ Centered / Decentered ☐

Posterior Capsule: ☐ Clear / Cloudy ☐

Additional Comments:_____

_____

Next visit:_____ With Dr._____

OD Signature:_____

Please Fax completed form to:

AFFILIATE RELATIONS DEPARTMENT
Affiliate Communications Team: FAX (517) 817-0141
Affiliate Communications Team: PHONE: (866) 399-1790