SPECIALTY EYE INSTITUTE

Cataract Post-op Reporting Form

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

SURGEON: Select from drop down list

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

OD

Date of Surgery: _____

Lens:

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

BCVA: 20 / _____

Manifest Refraction: _____

IOP: _____

IOL Status: ☐ Centered / Decentered ☐

Posterior Capsule: ☐ Clear / Cloudy ☐

OS

Date of Surgery: _____

Lens:

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