SPECIALTY EYE INSTITUTE

VISIAN ICL Post-op Reporting Form

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

SURGEON:

Luis Gago, MD

OD	OS
Date of Surgery: _____	**Date of Surgery:** _____
Lens: ☐ Monofocal ☐ Toric/Axis @_____	**Lens:** ☐ Monofocal ☐ Toric/Axis @_____
UCVA: 20/ _____	**UCVA:** 20/ _____
BCVA: 20 / _____	**BCVA:** 20 / _____
Manifest Refraction:_____	**Manifest Refraction:**_____
IOP: _____	**IOP:** _____
Lens Vault:	**Lens Vault:**
Lens: ☐ Clear ☐ Opacity	**Lens:** ☐ 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