



**SPECIALTY EYE
INSTITUTE**

Cataract Post-op Reporting Form

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

SURGEON:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Ronald Brown, MD | <input type="checkbox"/> Paul Ernest, MD | <input type="checkbox"/> Lance Lemon, MD | <input type="checkbox"/> Neal Tolchin, MD |
| <input type="checkbox"/> Charlie Chai, MD | <input type="checkbox"/> Luis Gago, MD | <input type="checkbox"/> Marcus Rhem, MD | <input type="checkbox"/> RaShawn Venerable, DO |
| <input type="checkbox"/> Alexander Cherry, MD | <input type="checkbox"/> James Ravin, MD | <input type="checkbox"/> Anthony Sensoli, MD | |
| <input type="checkbox"/> Mahmoud El-Yassir, MD | <input type="checkbox"/> Kevin Lavery, MD | <input type="checkbox"/> Clint Simpson, MD | |

OD

Date of Surgery: _____

Lens:

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Monofocal | <input type="checkbox"/> Toric/Axis @ _____ |
| <input type="checkbox"/> Clearon | <input type="checkbox"/> Femto Laser |
| <input type="checkbox"/> Crystalens | <input type="checkbox"/> Symphony Toric/Axis @ _____ |
| <input type="checkbox"/> Symphony | <input type="checkbox"/> ReStor Toric/Axis@ _____ |
| <input type="checkbox"/> ReStor | <input type="checkbox"/> PanOptix Toric/Axis@ _____ |
| <input type="checkbox"/> PanOptix | <input type="checkbox"/> Vivity Toric/Axis@ _____ |
| <input type="checkbox"/> Vivity | <input type="checkbox"/> Other: _____ |

BCVA: 20 / _____

Manifest Refraction: _____

IOP: _____

IOL Status: Centered / Decentered

Posterior Capsule: Clear / Cloudy

OS

Date of Surgery: _____

Lens:

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Monofocal | <input type="checkbox"/> Toric/Axis @ _____ |
| <input type="checkbox"/> Clearon | <input type="checkbox"/> Femto Laser |
| <input type="checkbox"/> Crystalens | <input type="checkbox"/> Symphony Toric/Axis @ _____ |
| <input type="checkbox"/> Symphony | <input type="checkbox"/> ReStor Toric/Axis@ _____ |
| <input type="checkbox"/> ReStor | <input type="checkbox"/> PanOptix Toric/Axis@ _____ |
| <input type="checkbox"/> PanOptix | <input type="checkbox"/> Vivity Toric/Axis@ _____ |
| <input type="checkbox"/> Vivity | <input type="checkbox"/> 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 (313) 262-8816
Affiliate Communications Team: PHONE: (866) 399-1790