LASER OTTAWA VISION EXPERTS

CATARACT/RLE /ICL POST-OPERATIVE FORM

P 613-509-1313 | **F** 613-663-2971 | 1-844-319-5683 (LOVE)

Name _____ Phone _____ D.O.B. _____ Tx: ☐ CATARACT ☐ RLE ☐ ICL

Co-Managing Dr. _____ Dr. Phone _____ Dr. Fax _____ IOL Type: ☐ Monofocal ☐ OD ☐ OS

☐ Multifocal ☐ OD ☐ OS

☐ Toric ☐ OD ☐ OS

☐ ICL ☐ OD ☐ OS

Dr. Email _____ Surgery Date _____

Med: / Dosage: ☐ Prolensa _____ ☐ Vigamox _____ ☐ Maxidex _____

☐ Artificial Tears: _____

OD Target: ☐ Plano ☐ Other _____ **OS Target:** ☐ Plano ☐ Other _____

	OD	OS
UCDVA	20 /	20 /
UCNVA	20 /	20 /
For Multi IOLs UIVA	20 /	20 /
Refraction	_____ 20 /	_____ 20 /
Post Op K Reading (for all Multi & Toric IOLs)	_____/_____@_____	_____/_____@_____
SLIT LAMP	Wound: ☐ Intact _____ Cornea: ☐ Clear _____ AC: ☐ Deep ☐ Quiet _____ IOL: ☐ Good Position _____ Post Segment: ☐ Normal _____	Wound: ☐ Intact _____ Cornea: ☐ Clear _____ AC: ☐ Deep ☐ Quiet _____ IOL: ☐ Good Position _____ Post Segment: ☐ Normal _____
IOP	_____ mmHg	_____ mmHg

Next followup visit scheduled: _____ ☐ day ☐ week ☐ month ☐ year Follow up required with LOVE? ☐ Y ☐ N

Doctor's Comments/Treatment: ☐ excellent ☐ stable ☐ enhancement _____

Quality of Vision: ☐ Excellent ☐ Acceptable ☐ Poor (if poor, please comment) _____

Patient Satisfaction: ☐ Satisfied ☐ Not Satisfied (if not satisifed, please comment) _____

Comments _____

_____

Dr. Signature _____ Date _____