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POST-OPERATIVE CATARACT REFERRAL REPORT

PATIENT INFORMATION

Exam Date _____

Patient Name _____ Home Phone _____

Address _____ Age _____ DOB _____

Subjective Comments _____

EXAMINATION

Visual Acuity	SC	PH	Refraction	Best corrected VA
OD	(20/)	(20/)		(20/)
OS	(20/)	(20/)		(20/)

OD

OS

SLE	WNL	Other	WNL	Other
Cornea				
Wound				
A/C				
IOL				
P/CAP				
INDIRECT / 90D / 20D				
Disc				
Macula				
Other				

ASSESSMENT _____

PLAN _____

Please give this report to IEC Dr. _____ at ___ Grnwd ___ Plnfd ___ Indpls

Please call me to discuss this patient.

Referring Doctor _____ OD / MD Phone _____