



Charles O. McCormick, M.D.
 Nicholas R. Rader, M.D.
 William Keeling, Ph.D., M.D.
 David F. Box, M.D.
 Carissa M. Barina, M.D.

GREENWOOD
 30 N. Emerson Ave.
 Greenwood, IN 46143
 317-881-3937
FAX 317-887-4011

PLAINFIELD
 1100 Southfield #1320
 Plainfield, IN 46168
 317-839-7300
FAX 317-839-7500

INDIANAPOLIS
 6423 S. East Street
 Indianapolis, IN 46227
 317-782-8844
FAX 317-782-8983

www.indianaeyeclinic.com

POST-OPERATIVE CATARACT / YAG 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 _____