Shoreline Vision
Vision Care. For Life.™

POST OP CLEAR LENS EXCHANGE ASSESSMENT REPORT

Procedure: **Monofocal** **Toric IOL** **ReSTOR IOL** **CrystaLens IOL**

PATIENT INFORMATION

NAME _____ DATE _____ DOB ___/___/___

SURGEON _____ CO-MANAGING DOCTOR _____

(CIRCLE ONE) RIGHT EYE LEFT EYE BOTH EYES

(CIRCLE ONE) THIS VISIT _____DAYS WEEK 1 MONTH

VISION ASSESSMENT

UNCORRECTED VISION: OD 20/ OS 20/
BEST CORRECTED VISION: OD 20/ OS 20/

MANIFEST REFRACTION: OD _____
OS _____

EXAM

I.O.P READING: OD _____ OS _____

SLIT LAMP: OD _____
OS _____

OCULAR MEDICATION (AFTER THIS VISIT) please indicate dosage:

MEDS	PRED FORTE	ZYMAR	ACULAR LS
RIGHT EYE			
LEFT EYE			

COMMENTS _____

_____

EXAMINING DOCTOR _____ DATE _____

SIGNATURE _____ PLEASE FAX TO: 231-733-0566