

# IOL FOLLOW-UP



BATCHELET EYE  
— SURGICAL SOLUTIONS —

Phone: 724-766-0986 Fax 724-558-9960

PATIENT NAME \_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

PROCEDURE DATE(S) \_\_\_\_\_

DATE OF EXAM \_\_\_\_\_

\_\_\_\_\_ DAY / WEEK / MONTH FOLLOW-UP

**OD:**

**OS:**

UCVA: \_\_\_\_\_

UCVA: \_\_\_\_\_

REF: \_\_\_\_\_ 20/\_\_\_\_\_

REF: \_\_\_\_\_ 20/\_\_\_\_\_

IOP: \_\_\_\_\_

IOP: \_\_\_\_\_

CORNEA

CORNEA

AC/IRIS

AC/IRIS

LENS IN GOOD POSITION? Y / N

LENS IN GOOD POSITION? Y / N

DILATION? Y / N

DILATION? Y / N

FUNDUS:

FUNDUS:

PATIENT SATISFACTION:  Very Happy  Satisfied  Dissatisfied

ASSESSMENT: \_\_\_\_\_  
\_\_\_\_\_

PLAN: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Report Faxed to Batchelet Eye

Signature \_\_\_\_\_