Post-Cataract Assessment Report

Patient: ____ D.O.B. ______________

Last Name First Name MI

Assessment Date: ____________________ Procedure Date: OD __________OS__________

Surgeon: ______________________________ Premium IOL: ______________________

Brief HPI/CC:____

Assessment	OD ______Day/Week/Month	OS______Day/Week/Month
Uncorrected Visual Acuity: Dist OU 20/ _____ Inter OU 20/_____ Near OU 20/_____	Uncorrected Visual Acuity: Dist 20/ _____ Inter 20/ _____ Near 20/ _____	Uncorrected Visual Acuity: Dist 20/ _____ Inter 20/ _____ Near 20/ _____
Keratometry Pd: ____________________	Flat K __________@Axis _________ Steep K _________@ Axis _________	Flat K __________@Axis _________ Steep K _________@ Axis _________
Auto Refraction		
Manifest Refraction	______________________=20/_____	______________________=20/_____
IOP Method: TA/DCT/NCT/TonoPen	________mmgH	________mmgH Time ______ am/pm
AC Cell	Clear Trace +1 +2 +3 +4	Clear Trace +1 +2 +3 +4
Flare	Clear Trace +1 +2 +3 +4	Clear Trace +1 +2 +3 +4
Posterior Capsule		
Ocular Medications	Med: ____________________ Frequency: ________________	Med: ____________________ Frequency: ________________
	Med: ____________________ Frequency: ________________	Med: ____________________ Frequency: ________________
	Med: ____________________ Frequency: ________________	Med: ____________________ Frequency: ________________
	Med: ____________________ Frequency: ________________	Med: ____________________ Frequency: ________________

Final Rx:

Sphere	Cylinder	Axis	Prism	Base	Add
		x			+
		x			+

Tech: ___________ Scribe: __________

Other:

Comments/Questions: ____

Planned Follow Up Visit: ____

OD Signature: ______________________________ Printed Name: ____________________

Mail or Fax to: Eye Clinic of Wisconsin, S.C., 800 N. First Street, Wausau, WI 54403 Fax: 715.261.8665