eye clinic of wisconsin℠
One vision. Yours.℠

Post-Surgical 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: _____

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