GULFCOAST EYE CARE

Implantable Collamer Lens (ICL) Post Procedure Care

Patient Name:_____ Patient's Birthdate: _____/_____/_____

Co-Managing Doctor: _____

Doctor Email: _____ Doctor Phone/Fax: _____

Procedure: _____ Procedure Date: _____

Target: OD: ☐ DISTANCE ☐ NEAR ☐ MONOVISION OS: ☐ DISTANCE ☐ NEAR ☐ MONOVISION

POST OPERATIVE EXAM AND COMMENTS

1 Week 1 Month 3 Month

MEDS: _____ QID TID BID QD // OD OS OU

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UCVA: OD 20/_____ OS 20/_____ Blurry / Glare / Double / Fluctuating Vision

AUTO REFRACTION: _____

MANIFEST: DRY _____

BIOMICROSCOPY:

Adnexa: Normal Other:_____

Lids/Conj/Sclera: Normal Other: _____

Cornea: Normal Other: _____

Anterior Chamber: _____

Lens: _____

IOP: OD: _____ OS: _____

Doctor Signature: _____ **Date:** _____

GCEC is committed to providing the best are and results. Please fax to (727) 823-8796