Refractive Lens Exchange 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

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

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

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