

POST-OPERATIVE REPORT FOR STANDARD IOLs

JONES EYE CLINIC

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Date: _____

Patient's Name: _____

Co-Manage Dr: _____

Surgery Date: OD _____ Post-op: 1 day 2 wk 3 mth 6 mth other _____
OS _____ 1 day 2 wk 3 mth 6 mth other _____

CC: _____

Ocular Meds: _____

VA without correction:

OD: Distance 20/ _____ Near 20/ _____ Intermediate 20/ _____
OS: Distance 20/ _____ Near 20/ _____ Intermediate 20/ _____
OU: Distance 20/ _____ Near 20/ _____ Intermediate 20/ _____

PH/SPH: OD: 20/ _____ OS: 20/ _____ IOP: OD: _____ OS: _____ Ta/Tp

Auto Refraction: OD _____ 20/ _____
OS _____ 20/ _____

Manifest Refraction: OD _____ 20/ _____
OS _____ 20/ _____

Auto Keratometry:

Manual Keratometry:

OD _____
OS _____

OD _____
OS _____

Slit Lamp Exam:

OD _____ OS _____

Conjunctiva

Cornea

Iris

Anterior Chamber

IOL Position

Incision

Posterior Capsule

Retina/Mac

Recommendation/Plan:

Doctors Signature: _____