Co-Managing Doctor Postoperative YAG Laser Report

Patient Name:		
City:	State:	
Laser Date:	Surgeon:	

POSTOPERATIVE EXAM	EXAM
Exam Date	
Refraction: Sphere	
Refraction: Cylinder	
Refraction: Axis	
VA-without correction FAR	
VA-with correction FAR	
Cornea	
A.C. Depth	Normal Shallow
IOL Status	Centered Malpositioned
Lens Deposits	None Mild High
Posterior Capsule Open	☐ Yes ☐ No
IOP	OD: OS:
Tonometry Method	Goldman NCT Pneumo
Cup:Disc	OD: OS:
Dilated Fundus Exam with BIO (within 90 days PO)	
Holes/Tears	☐ Yes ☐ No
Medication Schedule	
Comments	
Doctor's Signature	

IF ANY SEVERE PAIN AND/OR RAPID DECREASE IN VISION DEVELOPS, AN IMMEDIATE CONSULTATION IS IN ORDER

PLEASE FAX FORMS TO 910-295-5526 Attn: POST OP TRACKING