GIMBEL EYE CENTRE

Primary Eye Care Provider Cataract Surgery Follow-Up Form

PLEASE TYPE / PRINT

Patient Name (Mr./Mrs./Ms.):_____

DOB (m/d/y):_____ Follow-Up Exam Date (m/d/y): _____

City: _____ Patient's Telephone:_____

Assessing Dr.: _____ ☐ OD ☐ MD

City: _____ Surgery Date (m/d/y):_____

EXAMINATION	OD	OS
Visual Acuity Without Correction	_____	_____
Manifest Refraction	_____	_____
Keratometry	_____	_____
Visual Acuity With Above Refraction	_____	_____
Intraocular Pressure by ☐ NCT ☐ AT	_____ mm Hg	_____ mm Hg

Slit Lamp

	OD		OS	
AC clear	☐ Yes	☐ No	☐ Yes	☐ No
Cornea clear	☐ Yes	☐ No	☐ Yes	☐ No
IOL centred	☐ Yes	☐ No	☐ Yes	☐ No
Posterior Capsule clear	☐ Yes	☐ No	☐ Yes	☐ No
Retina Posterior Pole intact	☐ Yes	☐ No	☐ Yes	☐ No

Additional Observations, Comments or Questions: _____

_____

_____

Is the patient satisfied with the surgical outcome? ☐ Yes ☐ No

If No, please indicate why the patient is dissatisfied. _____

_____

Next visit scheduled (m/d/y): _____ Would you like a reply? ☐ Yes ☐ No

Assessing Doctor's Fax:_____ _____

Signature of Assessing Doctor

FOR GEC OFFICE USE ONLY

Surgeon Comments: _____

_____

☐ Gimbel Eye Centre Calgary Fax: (403) 286-2943