NORTH IDAHO EYE INSTITUTE

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REFERRAL POST OP FORM

Surgeon: _____

Patient Name: _____ DOB: _____ Exam Date: _____

	VA sc	NVA sc	Manifest Refraction	VA cc	IOP
OD	_____	_____	_____	_____	_____
OS	_____	_____	_____	_____	_____

Right Eye

PO: 1 2 3 4 __

Cornea: 0 trace 1+ 2+ 3+ 4+ edema

AC: 0 trace 1+ 2+ 3+ 4+ cells or flare

IOL: _____ well positioned

Capsule: _____ clear

Other findings: _____

_____

_____

Assessment: _____

Plan: _____

	Low				High
OD satisfaction:	1	2	3	4	5
Patient satisfaction:	1	2	3	4	5

Dr. _____

Left Eye

PO: 1 2 3 4 __

Cornea 0 trace 1+ 2+ 3+ 4+ edema

AC 0 trace 1+ 2+ 3+ 4+ cells or flare

IOL: _____ well positioned

Capsule: _____ clear

Other findings: _____

_____

_____

Assessment: _____

Plan: _____

	Low				High
OD satisfaction:	1	2	3	4	5
Patient satisfaction:	1	2	3	4	5

Dr. _____

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