

# CLEARVIEW

## POST-OPERATIVE assessment report (RLE)

Patient Name: \_\_\_\_\_ DOB: m\_\_\_/d\_\_\_/y\_\_\_ Age: \_\_\_

Procedure Date: m\_\_\_/d\_\_\_/y\_\_\_ Surgeon: \_\_\_\_\_

Procedure performed: \_\_\_\_\_

Exam Date: m\_\_\_/d\_\_\_/y\_\_\_

Note: Aspheric IOL: Assessment required at 1 month, 12 months,  
MF: Assessment required at 1 month, 3 month, 1 Year

❖ <b>Uncorrected VA:</b>	OU 20/____	OD 20/____	OS 20/____	Reading: J___
❖ <b>Manifest Refraction:</b>	OD _____	20/____	OS _____	20/____
❖ <b>Keratometry Readings:</b>	OD K1___K2___	AXIS___	OS K1___K2___	AXIS___
❖ <b>Pachymetry</b>	OD _____		OS _____	
❖ <b>IOP</b>	OD _____	mm Hg	OS _____	mm Hg
❖ <b>AC Reaction</b>	OD _____		OS _____	

clear	trace	mild	clear	trace	mild
moderate	severe		moderate	severe	

• **OCULAR MEDICATION:** OD \_\_\_\_\_ OS \_\_\_\_\_  
(Following this visit) OD \_\_\_\_\_ OS \_\_\_\_\_  
OD \_\_\_\_\_ OS \_\_\_\_\_

<b>Comments/Questions</b>	
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Referring Doctor: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: m\_\_\_/d\_\_\_/y\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please Fax back to CLEARVIEW Institute at 416-289-2318 after each visit. Thank you.