GIMBEL EYE CENTRE®

Primary Eye Care Provider Cataract Surgery Follow-Up

PLEASE TYPE / PRINT

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

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		
Visual Acuity With Above Refraction		
Intraocular Pressure by ☐ NCT ☐ AT	mm Hg	mm Hg
Slit Lamp — 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) 202-3338 ☐ Gimbel Eye Centre Edmonton Fax: (780) 452-4114