REFRACTIVE/ CATARACT SURGERY
POST OP ASSESSMENT

CENTRE FOR SIGHT

Patient name: _____ DOB: _____

Address: _____

Email: _____ Tel: _____

Date/time: _____ Allergies: _____

_____ Days 1 month 3 months 6 months (please circle)

PC & HPC: _____

Eye Meds: 1. _____ Other Meds: _____

2. _____

Va

RE	ua	GI	PH
LE	ua	GI	PH

uaNv

	40	60	80
RE			
LE			

PACH: **RE** _____ **LE** _____

	sph	cyl		axis
MR			x	
			x	
AR			x	
			x	
K			x	
			x	

EXAMINATION:

LIDS / ADNEXAE

RIGHT _____

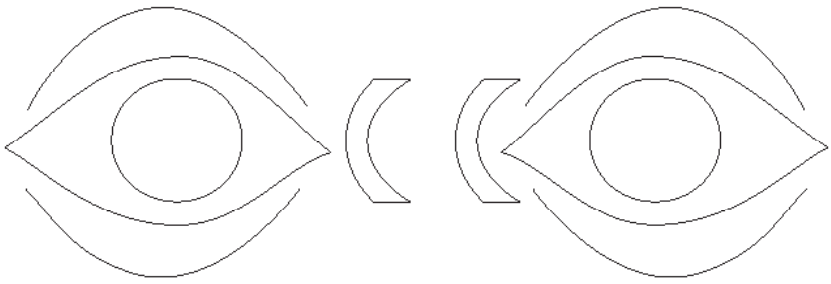
LEFT _____

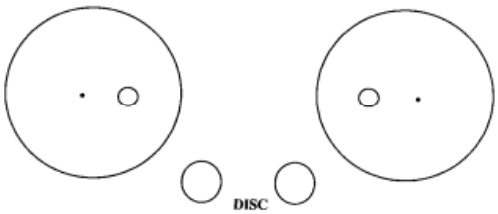
T RE _____

LE _____

App NCT PEN

DILATED FUNDUS EXAMINATION





Lens: _____

PLAN: _____

MEDICATION:

1. _____

2. _____

3. _____

SIGNED: _____

REVIEWED AT CFS BY: _____

FOR REVIEW: _____

LOCATION: _____

PRACTICE STAMP:

KEY: MR: Manifest Refraction AR: Autorefraction K: Keratometry