Price Vision Group
Verisyse/ICL Comanagement Post-op Report

Patient Name: _____ Date of Visit: _____
Surgeon: __Dr. Price Surgery Date: _____OD _____ OS

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C.C. □ doing well, no complaint □ blurred vision Current Medications:
□ discomfort, photophobia □ flashes, floaters _____
□other _____ _____

Post-op visit: Day 1 1 Week 1 Month _____ Other

Uncorrected Vision: 20/____ OD Refraction: _____ OD 20/____
20/____ OS _____ OS 20/____

Slit Lamp Exam: (Please circle findings)

Conjunctiva:	Norm, Injection
Epithelium:	Norm, SPK, or Defect
Stroma:	Norm, Edema
Endothelium:	Norm, Folds
Anterior Chamber:	Clear, Iritis, Other (Specify)
Verisyse:	clear, pigment deposits
Lens:	clear, cataract

Intraocular Pressure:
_____mmHg OD
_____mmHg OS

Fundus Exam: (Please Circle)
Normal, CME, ARMD,Other
_____

Medication Plan: □ Pred Forte tidx1wk, bidx1wk,qdx1wk and D/C
□Acular qid until bottle gone (2 mos.)
□Other _____

Return Visit: _____

Comments :_____
_____

Exam Checked By:

_____
Signature

Please fax to (317) 814-2848 attn: Refractive Dept.