Fax to 907-569-1564 or mail to:
Alaska Lasik and Cataract Center
235 E. 8th Ave, Suite 3A
Anchorage, AK 99501

Cataract Surgery 4-6 Week Post-op Report

Patient's Name____________________________ Date of Surgery_____________________

Examining Doctor__________________________ Date of Exam_______________________

RIGHT EYE

Refraction_____-______x______ 20/____

LEFT EYE

Refraction_____-______x______ 20/____

How do you rate this patient's satisfaction?

□ Very Satisfied □ Satisfied □ Neutral □ Dissatisfied □ Very Dissatisfied

Comments____
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Signed______________________________
Doctor's Signature