|  |  |
| --- | --- |
| Name  Age/Gender  Mobile No  Address | Branch  Case No:  Date:  Ref By: |

Optical Biometry, Pre-Op Workup and Surgery Plan

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Keratometry | | Topography | | Astigmatism | WTW | ACD | AL |
| RE |  | |  | |  |  |  |  |
| LE |  | |  | |  |  |  |  |
|  | Schirmer | IOP | Pachy | Pupil | A Kappa | Specular | Aberrometry | ROPLAS |
| RE |  |  |  |  |  |  |  |  |
| LE |  |  |  |  |  |  |  |  |
|  | Formula | A-Constant | IOL Power and Model | | Target Refraction | Notes | | |
| RE |  |  |  | |  |  | | |
|  |  |  | |  |  | | |
| LE |  |  |  | |  |  | | |
|  |  |  | |  |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Anterior Segment | Posterior Segment | Refraction/UCVA/BCVA | OCT |
| RE |  |  |  |  |
| LE |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Systemic Conditions | Ophthalmic Conditions | Possible Complications and Secondary Procedures |
|  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Special Instructions | Incision Planned |  |  |
| RE |  |  |
| LE |  |  |

|  |  |
| --- | --- |
| Name  Age/Gender  Mobile No  Address | Branch  Case No:  Date:  Ref By: |

**Surgery Plan and Consent**

|  |  |  |  |
| --- | --- | --- | --- |
| Admission Date | Admission Time | Operation Eye | Surgeon |
|  |  |  |  |

|  |  |
| --- | --- |
| Operation Plan |  |
| Visual Prognosis |  |
| Refractive Prognosis |  |
| Ophthalmic Difficulties |  |
| Systemic Difficulties |  |
| Possible Complications and secondary procedures |  |
| Expected Expense |  |

**Patient’s consent: I have read and understood the surgery plan in detail and I permit to perform the same. I have received the copy of it. Also, I understand that this is just a surgery plan. Actual execution of procedure and expense may differ from shown here in unusual situations. I agree to comply with it.**

**Important: This is just an overview of your personalized surgery plan. Complete details of all possible risk-factors and concerns have been mentioned in your informed consent. Please go through it carefully and sign it.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
|  |  |  |  |
| Date | Surgeon’s Signature | Patient’s Signature | Witness |