Reset Form

New York Eye and Ear Infirmary of Mount Sinai

Intraocular Lens Verification Form

Patient Name:

DOB:

Surgeon:

Date of Surgery:

Operative Eye (circle) ☐ **Right** ☐ **Left**

Intraocular Lens

Primary: **Manufacturer:**

Model:

Power (diopter):

Physician's Signature: _____

Date: **Time:**