** Please Return the completed form with each lens **

PRECISION LENS

Clinical Requisition Medical Device Reporting Form - Intraocular Lens (IOL)

Toll Free: 800-514-1095
Main: 952-358-0414
Fax : 952-881-2453

Date of Event:	Account Number:	RGA Number:	
PRODUCT INFORMATION AND EVENT SPECIFICS - CARTRIDGE /IOL			
IOL Model Number & Diopter	IOL Serial Number	Cartridge Type Used	Cartridge Lot Number
☐ Opened/not used (not product issue/doctor changed mind)			
Did the lens or cartridge contact the patient's eye?	☐ No ☐ Yes: ☐ cartridge only; ☐ Lens; ☐ customer does not know		
Extent of patient contact with lens: ☐ Fully inserted ☐ Partially inserted		Was the lens explanted in secondary surgical procedure? ☐ Yes ☐ No Implant Date: Explant Date:	
Was the lens removed and replaced in same procedure? ☐ Yes ☐ No		Was the procedure completed using another IOL? If yes provide: Model: SN:	

EVENT COMPLICATIONS (PLEASE CHECK ALL BOXES THAT APPLY

Product Related

☐ Loading Issue	☐ Bent / Broken Haptic	☐ IOL Torn.	☐ Lens Stuck in Cartridge
☐ Folding Issue.	☐ Missing / Detached Haptic	☐ Debris on Lens.	☐ Cartridge Broke / Cracked
☐ IOL missing	☐ Lens Scratched	☐ Handling problem/ Use error.	☐ Tip Cracked/Deformed
☐ IOL Rotation > or equal to 10 degrees		☐ Lead Haptic not Folded	☐ Trailing Haptic not Folded

Other, please describe:

Medical Related

☐ Capsule Tear / Collapse ☐ Infection / Inflammation ☐ Halos / Glare ☐ Incision enlargement ☐ Unplanned sutures
☐ Vitrectomy. ☐ Unexpected Post-op Refraction ☐ Other Visual Disturbance ☐ NA

Summary of Event:	*Date of symptom onset?* *Symptoms:*

When problem Observed

☐ Upon Opening Package ☐ During handling prior to insertion ☐ While Inserting into the eye ☐ After Insertion ☐ During post- exam

Was product returned to Precision Lens? ☐ Yes ☐ No Reason for no return? ☐ Discarded ☐ Still implanted

FACILITY CONTACT / PATIENT INFORMATION

Name of Account:		Facility Address:	
Facility City/State		Phone number:	
Physician/Surgeon:		Attending Nurse/Tech:	
Gender: Male or Female	Intersex, Transgender, No info, Prefer not to Disclose	DOB : Patient Initial;	Eye affected: ☐ Left (OS) ☐ Right (OD) ☐ Both
Outcome significantly inter feres with activities of daily life: ☐ YES ☐ NO		Weight in Pounds:	
Ethnicity: (Hispanic/Latino or Not Hispanic/Latino:		Race: Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian, Pacific Islander or White	
Current Patient Status: ☐ Permanent Impairment ☐ Patient Has Recovered ☐ Unknown			
*Required for All Reports, Completed By (Please Print):		Phone Number:	