

CATARACT/RLE POST - OPERATIVE FORM

Toll Free: 877-230-2020
Phone: 705-797-1700
Fax: 705-797-1800

Name: _____ Phone: _____ D.O.B. _____ Tx: CATARACT / RLE

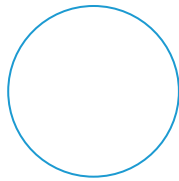
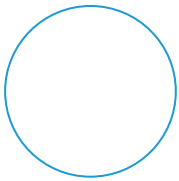
Co-Managing Doctor: _____ Doctor Phone: _____ Doctor Fax: _____ Doctor Email: _____

Original Treatment Date: _____ Post-operative Date: _____ IOL Type: Monofocal OD / OS Multifocal OD / OS
 Toric OD / OS

Meds / Dosage: Steroid _____ / Antibiotic _____ / Artificial Tears: PF / Regular _____ NSAID / _____

OD Target: Plano / Other: _____

OS Target: Plano / Other: _____

UCDVA	20 / (blurry / glare / dbl / fluctuates)	20 / (blurry / glare / dbl / fluctuates)
UCNVA	20 / (blurry / glare / dbl / fluctuates)	20 / (blurry / glare / dbl / fluctuates)
Refraction	20 /	20 /
SLIT LAMP	<p>Wound: <input type="checkbox"/> Intact _____</p> <p>Cornea : <input type="checkbox"/> Clear _____</p> <p>AC: <input type="checkbox"/> Deep / Quiet _____</p> <p>Pupil: <input type="checkbox"/> Equal / Reactive _____</p> <p>IOL: <input type="checkbox"/> Good Position _____</p> <p>RR: <input type="checkbox"/> Normal _____</p> <div style="text-align: center; margin-top: 20px;"></div>	<p>Wound: <input type="checkbox"/> Intact _____</p> <p>Cornea: <input type="checkbox"/> Clear _____</p> <p>AC: <input type="checkbox"/> Deep / Quiet _____</p> <p>Pupil: <input type="checkbox"/> Equal / Reactive _____</p> <p>IOL: <input type="checkbox"/> Good Position _____</p> <p>RR: <input type="checkbox"/> Normal _____</p> <div style="text-align: center; margin-top: 20px;"></div>
IOP	mmHg	mmHg

Instructions Provided: Drops: Reviewed Next follow-up visit scheduled: _____ day / week / month / year Follow-up required with BLC: (Y) (N)

Doctors comments / Treatment: excellent / stable / enhancement _____

Quality of Vision: Excellent Acceptable Poor (if poor, please comment)

Patient Satisfaction: Excellent Not satisfied (if not satisfied, please comment)

Comments: _____

Dr. Signature: _____ Date: _____