



Post Operative Cataract Report

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Patient Name: _____ **Date:** _____

Primary Care OD: _____ **Patient DOB:** _____

Date of Surgery: _____ **Surgical Eye:** (circle one) RIGHT or LEFT

CC: _____

Post Operative Visit: (circle one): 1day // 1 week // 2 weeks // 3 weeks // 3 months // other: _____

Medication	Which Eye?	How Often	Last used
Antibiotic (Zymar or similar)			
Steroid (Pred Forte or similar)			
NSAID (Acular or Voltaren)			

Visual Acuity without correction: 20/_____ **Pinhole:** 20/_____

Refraction: (circle one): manifest / AR / quick streak: _____ **BVA:** _____

SLEX

Wound: _____
Cornea: _____
Iris/Pupil: _____
AC: _____
IOL: _____
Post. Capsule: _____

A few examples (circle if appropriate)

(intact, tight, no signs of dehiscence)
(clear, folds, striae, edema, spk, abrasion)
(round, oblong, reactive, non-reactive)
(cells, flare, clear, deep, quiet, shallow)
(PCIOL, centered, decentered)
(clear, cloudy, fibrous, opaque)

IOP: _____ **DFE performed?** _____ Yes _____ No

Impressions:

Plans and Patient education: (PLEASE CHECK ALL THAT APPLY)

1. () Begin or continue: Antibiotic/Pred Forte / Acular as per instruction sheet
2. () Post op instructions discussed with patient
3. () Avoid water in/on operated eye. Avoid rubbing or pressure on operated eye
4. () Discussed signs and symptoms of endophthalmitis. If symptoms occur call immediately
5. () Discussed 24 hour on-call service with patient if problems develop -- call your office or HEC
6. () If abnormal symptoms -- call your office or HEC ASAP
7. _____: **Date of next postoperative appointment with referring doctor**

PLEASE FAX THIS FORM TO 731-664-2903 ASAP