



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: _____

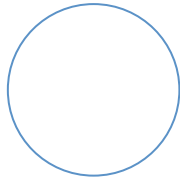
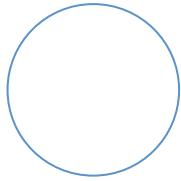
Original Treatment Date: _____ Post-operative Date: _____ IOL Type: Monofocal OD/OS Multifocal OD/OS

Toric OD/OS

Meds / Dosage: Steroid _____ / Zymar _____ / Artificial Tears: PF / Regular _____

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> 	<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> 
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: Satisfied Not satisfied (if not satisfied please comment)

Comments: _____

Dr. Signature: _____ Date: _____