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:** _____

	OD	OS
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	Wound: ☐ Intact _____ Cornea : ☐ Clear _____ AC: ☐ Deep / Quiet _____ Pupil: ☐ Equal / Reactive _____ IOL: ☐ Good Position _____ RR: ☐ Normal _____	Wound: ☐ Intact _____ Cornea: ☐ Clear _____ AC: ☐ Deep / Quiet _____ Pupil: ☐ Equal / Reactive _____ IOL: ☐ Good Position _____ RR: ☐ Normal _____
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:** _____