# Eye Care of Delaware Cataract Post-Op Report Form

**Patient's Name:** _____ **Exam Date:** _____

**Doctor:** _____ **Patient DOB:** _____

**Cataract Extraction:** **OD *(date)* :** _____ **OS *(date)* :** _____

☐ Monofocal ☐ Femto/LRI ☐ Toric ☐ *Symfony/* ReSTOR ☐ *Symfony Toric*

**CC:** _____

**Medications:** ☐ Dropless (Triamcinolone) ☐ Combo Drops (Pred-Geti-Bromfenac)

☐ Ofloxacin ☐ Tobramycin ☐ Durezol ☐ Prolensa

OD dose: _____ x/day OD dose: _____ x/day OD dose: _____ x/day

OS dose: _____ x/day OS dose: _____ x/day OS dose: _____ x/day

## Examination of Operated Eye

**OD Post-Op Visit** week 1 2 3 4 5 6 7 8 9 10 11 12 Other: _____

**OS Post-Op Visit** week 1 2 3 4 5 6 7 8 9 10 11 12 Other: _____

**VA without Correction** OD 20/ _____ Pinhole 20/ _____ Near J _____

OS 20/ _____ Pinhole 20/ _____ Near J _____

**Refraction** OD _____ VA _____ **Keratometry** OD _____

OS _____ VA _____ OS _____

| **Slit Lamp Exam** | **OD** | | | **OS** | | |
|---|---|---|---|---|---|---|
| **C/S** | WNL | Injection _____ | | WNL | Injection _____ | |
| **Wound** | Intact | | | Intact | | |
| **Cornea** | Clear | Edema _____ | Striae _____ | Clear | Edema _____ | Striae _____ |
| **A/C** | Quiet | Cell/Flare _____ | | Quiet | Cell/Flare _____ | |
| **Pupil** | Round | Dilated | | Round | Dilated | |
| **IOL Status** | Centered | Toric IOL Axis _____ | | Centered | Toric IOL Axis _____ | |
| **Post Capsule** | Clean | Hazy | Wrinkled | Clean | Hazy | Wrinkled |
| **Macula** | Normal | Cystoid Edema | AMD | Normal | Cystoid Edema | AMD |
| **Fundus** | _____ | | | _____ | | |

**Tension (Applanation)** OD _____ mm Hg OS _____ mm Hg

**Impression and Plan:** _____

_____

**Next Appointment:** _____

**Signature:** _____

EYE CARE OF DELAWARE LLC

*Fax: 302-454-8801*

*If any severe pain and/or decrease in vision develops, an immediate consultation is indicated*