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 ☐ *PanOptix/Odyssey* ☐ *Light Adjustable*

CC: _____

Medications: ☐ Dropless (Triamcinolone) ☐ Combo Drops (Pred-Moxi-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