BURLINGTON
LASER EYE CENTRE

CATARACT/RLE POST-OPERATIVE FORM

Fax: 905-632-9778

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 _____

	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 followup visit scheduled:** _____ ○ day ○ week ○ month ○ year **Follow up required with BLEC?** ○ Y ○ N

Doctor's Comments/Treatment: ○ excellent ○ stable ○ enhancement _____

Quality of Vision: ○ Excellent ○ Acceptable ○ Poor (if poor, please comment) _____

Patient Satisfaction: ○ Satisfied ○ Not Satisfied (if not satisifed, please comment) _____

Comments _____

_____

Dr. Signature _____ **Date** _____