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 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:** ______________________