Referring Doctor Post Operative Cataract Exam

Patient Name:_______________________________________ **Date**:___________________________

Primary Care OD:____________________________________ **Patient DOB**:____________________

Date of Surgery:______________________ **Surgical Eye**: (circle one) RIGHT or LEFT

CC:____

Post Operative Visit: (circle one): 1day // 1 week // 2 weeks // 3 weeks // 3 months // other:_______

Medication	Which Eye?	How Often	Last used
Antibiotic (Zymaxid or similar)			
Steroid (Pred Forte or similar)			
NSAID (Prolensa or similar)			

Visual Acuity without correction: 20/_______ __________ _ _________PH: 20/________
Refraction: (circle one): manifest / AR / quick streak: _________________________ _ _BVA: 20/_ _____

SLEX:
Wound:____________________________
Cornea:_____________________________
Iris/Pupil:__________________________
AC:________________________________
IOL:_______________________________
Post. Capsule:______________________

Examples (circle if appropriate):
(intact, tight, no signs of dehiscence)
(clear, folds, striae, edema, spk, abrasion)
(round, oblong, reactive, non-reactive)
(cells, flare, clear, deep, quiet, shallow)
(PCIOL, centered, decentered)
(clear, cloudy, fibrous, opaque)

IOP:____________

DFE performed? ____ Yes______ No

Impression:____

Plan/Patient education: (check all that apply)
1. ( ) Begin or continue: Antibiotic/ Steroid / NSAID as per instruction sheet.
2. ( ) Post op instructions discussed with patient.
3: ( ) Avoid water in/on operated eye. Avoid rubbing or pressure on operated eye.
4. ( ) Discussed signs and symptoms of endophthalmitis. If symptoms occur, call immediately.
5. ( ) Discussed 24 hour on-call service with patient if problems develop -- call your office or HEC.

Date of next postoperative appointment:____

PLEASE FAX THIS FORM TO (731) 664-2903 ASAP