



**COMANAGING DOCTOR
POST OPERATIVE FORM**

Comanaging Doctor: _____ **Date:** _____

Patient Name: _____ **Patient DOB:** _____

OD	OS
Post Op Visit	Post Op Visit
1 day / 1 wk / 2 wk / 3 wk / 1 month / Other: _____	1 day / 1 wk / 2 wk / 3 wk / 1 month / Other: _____
Uncorrected Vision: 20/_____ PH: 20/_____	Uncorrected Vision: 20/_____ PH: 20/_____
Refraction: _____	Refraction: _____
IOP: _____	IOP: _____
Exam:	Exam:
Wound: _____ (intact, tight, no dehiscence)	Wound: _____ (intact, tight, no dehiscence)
Cornea: _____ (clear, edema, folds, SPK, abrasion)	Cornea: _____ (clear, edema, folds, SPK, abrasion)
Iris/Pupil: _____ (flat, round, dilated, oblong)	Iris/Pupil: _____ (flat, round, dilated, oblong)
A/C: _____ (quiet, cell, flare, deep, shallow)	A/C: _____ (quiet, cell, flare, deep, shallow)
IOL: _____ (PCIOL, centered, decentered)	IOL: _____ (PCIOL, centered, decentered)
Capsule: _____ (clear, cloudy, fibrous)	Capsule: _____ (clear, cloudy, fibrous)
Eye Status:	Eye Status:
____ Eye is healing appropriately	____ Eye is healing appropriately
____ Ok to proceed with 2 nd eye surgery	____ Ok to proceed with 2 nd eye surgery
____ Eye is unstable (call 731.664.1994)	____ Eye is unstable (call 731.664.1994)

Discussion with Patient:

Review PO instructions, including no pressing, pressure, rubbing, or water directly on/in surgical eye for 7 days. Instruct patient to wear shield over surgical eye while sleeping for 7 days. Stress compliance with all postoperative eyedrops. Discuss signs and symptoms of endophthalmitis. If symptoms occur, call immediately. Stress importance of postoperative visits to monitor healing.

Alerts for Surgeon: _____

Date of Next PO visit: _____

**PLEASE FAX THIS FORM TO 731.664.2903
CALL 731.664.1994 WITH ANY CONCERNS**