

Comanaging Doctor Postoperative Premium Lens Report

Co-Managing Doctor (Printed)				
Patient Name:			CEA Chart #	
Patient DOB:				
Surgery Date:		Surgeon:		Operated Eye <input type="checkbox"/> Right <input type="checkbox"/> Left
Type of Lens:				
Exam /Date	1 st Ex/Date:	2 nd Ex/Date:	3 rd Ex/Date:	4 th Ex/Date:
Refraction Sphere				
Refraction Cylinder				
Refraction Axis				
VA Uncorrected Operative Eye	Near	Near	Near	Near
	Far	Far	Far	Far
VA Uncorrected Both Eyes	Near	Near	Near	Near
	Far	Far	Far	Far
VA Uncorrected Intermediate Operative Eye				
VA Uncorrected Intermediate Both Eyes				
Corneal Edema				
Endothelial Deposits				
A.C. Depth				
A.C. Reaction				
Flare				
Pigmented Particles/White Cells				
IOL Status				
Lens Deposits				
Posterior Capsule Open				
Posterior Capsule Haze				
Seidel				
IOP (Method)				
Pt Wearing Glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, List Power				
Medication Schedule				
Comments				
Doctor's Signature				
Patient Release Date				

IF ANY SEVERE PAIN AND/OR RAPID DECREASE IN VISION DEVELOPS, AN IMMEDIATE CONSULTATION IS IN ORDER

Please FAX forms to (910) 295-5526 Attn: POST-OP TRACKING

ONE DAY POST-OP FORMS MUST BE RECEIVED WITHIN 48 HOURS