Co-Managing Doctor Postoperative Cataract Surgery Report

Co-Managing Doctor (Printed)			
Patient Name:		CEA Chart #	
Patient DOB:			
Surgery Date:	Surgeon:	Operated Eye ☐Right ☐Left	
Postoperative Exam	**1st Exam**	**2nd Exam**	**3rd Exam**
Exam Date			
Refraction: Sphere			
Refraction: Cylinder			
Refraction: Axis			
VA-without correction FAR			
VA-with correction FAR			
VA-fellow eye with correction FAR			
Corneal Edema	NONE MILD HIGH	NONE MILD HIGH	NONE MILD HIGH
Endothelial Deposits	NONE MILD HIGH	NONE MILD HIGH	NONE MILD HIGH
A.C. Depth	NORMAL SHALLOW	NORMAL SHALLOW	NORMAL SHALLOW
A.C. Reaction			
Flare	CLEAR TRACE 1+ 2+	CLEAR TRACE 1+ 2+	CLEAR TRACE 1+ 2+
Pigmented Particles/White cells	CLEAR TRACE 1+ 2+	CLEAR TRACE 1+ 2+	CLEAR TRACE 1+ 2+
IOL Status	CENTERED MAPLOSITIONED	CENTERED MAPLOSITIONED	CENTERED MAPLOSITIONED
Lens Deposits	NONE MILD HIGH	NONE MILD HIGH	NONE MILD HIGH
Posterior Capsule Open	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Posterior Capsule Haze	NONE MILD HIGH	NONE MILD HIGH	NONE MILD HIGH
Incision Site Comments			
IOP (Method:)	OD: OS:	OD: OS:	OD: OS:
Cup: Disc	OD: OS:	OD: OS:	OD: OS:
Trabeculectomy ☐ Yes ☐No	FILTERING FLAT	FILTERING FLAT	FILTERING FLAT
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

ALL 1 DAY POST OP FORMS MUST BE RECEIVED WITHIN 48 HOURS