



Name: _____ Phone: _____ D.O.B: _____ Tx: CATARACT/ RLE

Co-Managing Doctor: _____ Doctor Phone: _____ Doctor Fax: _____ Doctor Email: _____

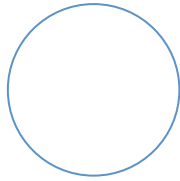
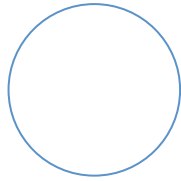
Original Treatment Date: _____ Post-operative Date: _____ IOL Type: Monofocal OD/OS Multifocal OD/OS

Toric OD/OS

Meds/ Dosage: Steroid _____ / Zymar _____ / Artificial Tears: PF/ Regular _____

OD Target: Plano/ Other: _____

OS Target: Plano/ Other: _____

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	<p>Wound: <input type="checkbox"/> Intact _____</p> <p>Cornea: <input type="checkbox"/> Clear _____</p> <p>AC: <input type="checkbox"/> Deep/ Quiet _____</p> <p>Pupil: <input type="checkbox"/> Equal/ Reactive _____</p> <p>IOL: <input type="checkbox"/> Good Position _____</p> <p>RR: <input type="checkbox"/> Normal _____</p> 	<p>Wound: <input type="checkbox"/> Intact _____</p> <p>Cornea: <input type="checkbox"/> Clear _____</p> <p>AC: <input type="checkbox"/> Deep/ Quiet _____</p> <p>Pupil: <input type="checkbox"/> Equal/ Reactive _____</p> <p>IOL: <input type="checkbox"/> Good Position _____</p> <p>RR: <input type="checkbox"/> Normal _____</p> 
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: _____