Please write legibly, all data is reviewed.

NRV Eye Center Post Operative Cataract Surgery Reporting Documentation

In case if urgent post-operative problem, page Dr. Puckett **540-224-0209**. If no answer, call local ophthalmologist.

WRX: OD _____

Co-managing Office/Doctor: _____ OS _____

Patient Name: _____ DOB: _____ Surgery Date(s) OD: _____ OS: _____

PreOP factors (circle if present): ARMD DME/CME ERM White cataract Dense Weak zonules low endothelial cell counts other: _____

Op Notes: MF IOL Toric IOL set to ____ axis Kenalog ____mg Hydrus Stent Other:

	Date _____	Date _____	Date _____	Date _____
S:				
Comfort level:	OD: *Good/Fair/Poor* OS: *Good/Fair/Poor*	OD: *Good/Fair/Poor* OS: *Good/Fair/Poor*	OD: *Good/Fair/Poor* OS: *Good/Fair/Poor*	OD: *Good/Fair/Poor* OS: *Good/Fair/Poor*
Problems:	OD: OS:	OD: OS:	OD: OS:	OD: OS:
Meds:	OD: OS:	OD: OS:	OD: OS:	OD: OS:
Ketorolac Ocuflox Prednisilone Other				
O:	*Unaided Pin Hole*	*Unaided Pin Hole*	*Unaided Pin Hole*	*Unaided Pin Hole*
VA sc	OD 20/ | OS 20/ |	OD 20/ | OS 20/ |	OD 20/ | OS 20/ |	OD 20/ | OS 20/ |
Ks	OD: OS:	OD: OS:	OD: OS:	OD: OS:
IOP:	OD: OS:	OD: OS:	OD: OS:	OD: OS:
MRX: *(circle if dispensed)*	OD _____20/ OS _____20/	OD _____20/ OS _____20/	OD _____20/ OS _____20/	OD _____20/ OS _____20/
SLE:	OD: OS:	OD: OS:	OD: OS:	OD: OS:
Epi: Cornea: Wound: AC: IOL: Post Cap:				
DFE: ON head Macula Periph.				
A:				
P:				

Fax form after each visit to NRV Eye Center PC 540-381-8680. Use high resolution setting