Kevin H. Cuevas, M.D.

Multifocal IOL CATARACT POST-OP REPORT FORM

PATIENTS' NAME____DATE__________________

REFERRING DOCTOR____

CATARACT EXTRACTION DATE: OD____________________OS_________________________

MEDICATIONS: OD____ QID TID BID QD
____ QID TID BID QD
OS____ QID TID BID QD
____ QID TID BID QD

CC/ADDITIONAL MEDS: ____

EXAMINATION OF OPERATED EYE(S) 4 week Post-op K's

POST-OP VISIT: OD: DAY ONE WEEK 1 2 3 4 5 6 7 8 9 10 11 12 ________/________@_____
OS: DAY ONE WEEK 1 2 3 4 5 6 7 8 9 10 11 12 ________/________@_____

DVA SC OD: 20/________ PH: 20/_______ OS: 20/________ PH: 20/_________
NVA SC 20/________ 20/________

MANIFEST REFRACTION OD: ____ VA: 20/_____
OS: ____ VA: 20/_____

SLIT LAMP EXAM (CIRCLE WITH COMMENTS)

WOUND/SUTURES	OD:	INTACT_______________________		SEIDEL________________
	OS:	INTACT_______________________		SEIDEL________________
CORNEA	OD:	CLEAR	STRIAE____________	EDEMA_______________
	OS:	CLEAR	STRIAE____________	EDEMA_______________
A/C	OD:	CLEAR	1+ 2+ 3+ 4+	CELL/FLARE
	OS:	CLEAR	1+ 2+ 3+ 4+	CELL/FLARE
IOL	OD:	CENTERED__________________		DECENTERED_______________
	OS:	CENTERED__________________		DECENTERED_______________
POST.CAPSULE	OD:	CLEAR	HAZY_____________	WRINKLED______________
	OS:	CLEAR	HAZY_____________	WRINKLED______________
MACULA	OD:	WNL	CME__________AMD_________	OTHER____________
	OS:	WNL	CME__________AMD_________	OTHER____________
FUNDUS	____			

TENSIONS (APPLANATION/NCT) OD:__________OS:__________mmHg@________AM/PM

IMPRESSION/PLAN____
____
____
____

Signature:____

****Immediate consultation indicated for any severe pain and/or decrease in vision****