

POST-OP REPORT FORM

PATIENTS' NAME _____ DATE _____

REFERRING DOCTOR _____

iLASIK / PRK / CATARACT

SURGERY DATE: OD _____ OS _____



ROCKY MOUNTAIN
OPHTHALMOLOGY

CENTER FOR CATARACT & LASIK SURGERY

MEDICATIONS: OD: _____ QID TID BID QD
 _____ QID TID BID QD
 OS: _____ QID TID BID QD
 _____ QID TID BID QD

CC/ADDITIONAL MEDS: _____

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

VA SC OD: 20/_____ PH: 20/_____ OS: 20/_____ PH: 20/_____
Near acuities: 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 _____

Flap alignment: normal displaced **Flap alignment:** normal displaced
Interface: clear opacities epi ingrowth **Interface:** clear opacities epi ingrowth
Edges: smooth rolled **Edges:** smooth rolled

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
(after two weeks if iLASIK)

IMPRESSION/PLAN _____

_____ Continue eye drops as directed
 Use shield/goggles QHS x 1 week
 Call with adverse event; redness, pain, or decrease in vision
**** Immediate consultation is indicated for any severe pain and/or decrease in vision **** Do not rub your eyes

Signature: _____

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