OMNI Eye Services: Cataract Surgery Post-Operative Report

Name _____ Date _____

Referring Doctor _____
Date of Surgery:

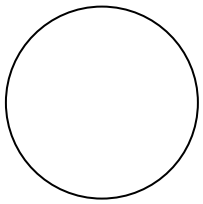
		Standard	Complex					
OD	_____ / _____ / _____	66984	66982	Lens Type:	Monofocal	ReSTOR	ReZoom	Other_____
OS	_____ / _____ / _____	66984	66982	Lens Type:	Monofocal	ReSTOR	ReZoom	Other_____

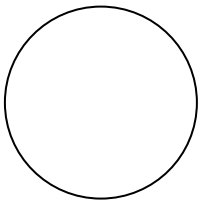
CC: _____

Vigamox	Q2H	Q3H	QID	TID	BID	QD	Vigamox	Q2H	Q3H	QID	TID	BID	QD
Zymar	Q2H	Q3H	QID	TID	BID	QD	Zymar	Q2H	Q3H	QID	TID	BID	QD
Pred Forte	Q2H	Q3H	QID	TID	BID	QD	Pred Forte	Q2H	Q3H	QID	TID	BID	QD
NSAID	Q2H	Q3H	QID	TID	BID	QD	NSAID	Q2H	Q3H	QID	TID	BID	QD
Cycloplegic				TID	BID	QD	Cycloplegic				TID	BID	QD
Other	_____						Other	_____					

Examination Findings

Visual Acuity @ Distance	sc / cc 20 /_____ PH 20 /_____	sc / cc 20 /_____ PH 20 /_____
@ Intermediate	20 /_____	20 /_____
@ Near	20 /_____	20 /_____
Refraction	_____	_____
Cornea	Clear ___ Folds(1→4+) ___	Clear ___ Folds(1→4+) ___
Anterior Chamber:		
Cells & Flare	Clear ___ (1→4+) ___	Clear ___ (1→4+) ___
Depth	Formed ___ Shallow ___	Formed ___ Shallow ___
IOL:		
Type	AC ___ PC ___	AC ___ PC ___
Position	Centered ___ Decentered ___	Centered ___ Decentered ___
Posterior Capsule Haze	Clear _____ Opacity (1→4+) _____	Clear _____ Opacity (1 →4+) _____
IOP	_____mm @ _____am / pm	_____mm @ _____am / pm
Fundus	_____	_____





Impression: Doing Well ____; Other _____

Plan:
OD OS Begin Vigamox, Zymar, Pred Forte, NSAID, Cycloplegic **Dosage:** Q2H, Q3H, Q4H, QID, TID, BID, QD
OD OS Continue all meds without change
OD OS Discontinue Vigamox, Zymar, Pred Forte, NSAID, Cycloplegic, Other_____
OD OS Taper Steroid QIDx1wk, TIDx1wk, BIDx1wk, QDx1wk, D/C
OD OS Other_____

Today's examination has determined that it is clinically appropriate to transfer care of the patient to their referring doctor. Yes No

Does the patient continue to experience functional difficulties at distance or near, despite a healing but stable result in th e operated eye, and wish to proceed with surgery in the other eye? Yes No

Next Appointment

OD	1,	2,	3 weeks;	1,	2,	3,	4 months;	other_____			
	Call patient for appointment ___			Appointment made (date & time): _____							
OMNI	1,	2,	3 weeks;	1,	2,	3,	4 months;	prn;	other _____		

Signature: _____

Fax to: Iselin 732-750-1507; Rochelle Park 201-368-0254; Parsippany 973-538-3007; West Orange 973-325-6738