▪ Post-op Co-management Progress Report

Name: ______________________________

DOS: ______________________________

DOB: ______________________________

Referred by: ________________________

Surgery Date ____________________ Procedure ______________________________ Eye OD OS

Surgeon:____________________ Post-Op Medication: ______________________________

IOL Type: Monofocal Monovision (____ for reading) Multifocal Accomodative

Date ________________________

History/Complaint:____

For Presbyopic-Correcting IOLs

VAsc OD __________________________ ____________ ____________

OS __________________________ ____________ ____________

(Distance) *(Intermediate)* *(Near)*

Refraction ________________________ 20/____ IOP _________ mmHg

SLE: LIDS: Ecchymosis Ptosis Wnl
Wound: Covered Seidel _______
Cornea: Edema Striae Clear
AC: _____+ Cell _____+ Flare
Pupil: Round Oval Peaked
IOL: Centered Decentered
Post Capsule: Clear Wrinkled Cloudy

Impression ____

Plan____

O.D. Signature ____

Date ________________________ 1 Week Cyclo Refraction for Crystalens - Surgical Eye Only

Cyclo Ref ____________________

For Presbyopic-Correcting IOLs

VAsc OD ________________ ____________ ____________

OS ________________ ____________ ____________

(Distance) *(Intermediate)* *(Near)*

K's OD ____________

OS ____________

Refraction OD ______________________________ 20/_____

OS ______________________________ 20/_____

IOP OD ____________ mmHg

OS ____________ mmHg

SLE: LIDS: Ecchymosis Ptosis Wnl
Wound: Covered Seidel _______
Cornea: Edema Striae Clear
AC: _____+ Cell _____+ Flare
Pupil: Round Oval Peaked
IOL: Centered Decentered
Post Capsule: Clear Wrinkled Cloudy

Fundus: Disc C/D ______________________
Macula: Edema Normal Drusen
Vessels: Normal Tortuous Attenuated
Periph: Flat
Comments ______________________
____

Impression ____

Plan ____

O.D. Signature ____

NOTE: Transfer of Post-op care is subject to the condition that if the patient develops increased intraocular pressure that is uncontrolled, increased conjunctival hyperemia or exudates, significant lid swelling, loss of vision, increased anterior chamber reaction, hyphema, hypopyon, or excessive pain, that the patient be returned to our care immediately. Thank you very much for your assistance in the care of this patient.

PLEASE FAX THIS TO BVA AFTER EACH POST-OP VISIT. Thank you, BVA.

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