

# OMNI EYE SERVICES POST-OP REPORT FORM

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_ OMNI SURGEON: \_\_\_\_\_

CATARACT EXTRACTION  \_\_\_\_\_ Eye \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Eye \_\_\_\_\_ Date \_\_\_\_\_

CC: \_\_\_\_\_

MEDICATIONS: _____	<input type="radio"/>	Eye _____	<input type="radio"/>	QID TID BID QD (CIRCLE ONE)	<input type="radio"/>	Eye _____	<input type="radio"/>	QID TID BID QD (CIRCLE ONE)
_____	<input type="radio"/>	Eye _____	<input type="radio"/>	QID TID BID QD (CIRCLE ONE)	<input type="radio"/>	Eye _____	<input type="radio"/>	QID TID BID QD (CIRCLE ONE)
_____	<input type="radio"/>	Eye _____	<input type="radio"/>	QID TID BID QD (CIRCLE ONE)	<input type="radio"/>	Eye _____	<input type="radio"/>	QID TID BID QD (CIRCLE ONE)
_____	<input type="radio"/>	Eye _____	<input type="radio"/>	QID TID BID QD (CIRCLE ONE)	<input type="radio"/>	Eye _____	<input type="radio"/>	QID TID BID QD (CIRCLE ONE)

### \*\*\*EXAMINATION OF OPERATED EYE\*\*\*

POST-OP VISIT: RIGHT EYE DAY 1 WEEK 1 2 3 4 5 6 7 8 9 10 11 12 Other \_\_\_\_\_  
 (CIRCLE ONE)

LEFT EYE DAY 1 WEEK 1 2 3 4 5 6 7 8 9 10 11 12 Other \_\_\_\_\_

VA WITHOUT CORRECTION: RIGHT EYE 20/\_\_\_\_\_ PINHOLE 20/\_\_\_\_\_

LEFT EYE 20/\_\_\_\_\_ PINHOLE 20/\_\_\_\_\_

REFRACTION OD \_\_\_\_\_ VA 20/\_\_\_\_\_

OS \_\_\_\_\_ VA 20/\_\_\_\_\_

### SLIT LAMP EXAM (CIRCLE WITH COMMENTS)

#### OD

#### OS

WOUND INTACT \_\_\_\_\_ SEPARATION \_\_\_\_\_

WOUND INTACT \_\_\_\_\_ SEPARATION \_\_\_\_\_

CORNEA CLEAR \_\_\_\_\_ STRIAE \_\_\_\_\_ EDEMA \_\_\_\_\_

CORNEA CLEAR \_\_\_\_\_ STRIAE \_\_\_\_\_ EDEMA \_\_\_\_\_

ANTERIOR CHAMBER 0 1+ 2+ 3+ 4+ CELL/FLARE

ANTERIOR CHAMBER 0 1+ 2+ 3+ 4+ CELL/FLARE

IOL STATUS CENTERED \_\_\_\_\_ DECENTERED \_\_\_\_\_

IOL STATUS CENTERED \_\_\_\_\_ DECENTERED \_\_\_\_\_

POST. CAPSULE CLEAR \_\_\_\_\_ HAZY \_\_\_\_\_ WRINKLED \_\_\_\_\_

POST. CAPSULE CLEAR \_\_\_\_\_ HAZY \_\_\_\_\_ WRINKLED \_\_\_\_\_

MACULA NORMAL \_\_\_\_\_ ABNORMAL \_\_\_\_\_

MACULA NORMAL \_\_\_\_\_ ABNORMAL \_\_\_\_\_

TENSIONS (APPLANATION) \_\_\_\_\_ mm Hg at \_\_\_\_\_ a.m./p.m.

TENSIONS (APPLANATION) \_\_\_\_\_ mm Hg at \_\_\_\_\_ a.m./p.m.

FUNDUS \_\_\_\_\_

FUNDUS \_\_\_\_\_

IMPRESSION AND PLAN: \_\_\_\_\_

IMPRESSION AND PLAN: \_\_\_\_\_

Signature: \_\_\_\_\_

**If any pain and/or decrease in vision develops, an immediate consultation is indicated  
 FOLD TOP COPY AND SEND TO OMNI • SECOND COPY REFERRING DOCTORS' RECORD**