NEWSOMEYE

You deserve NEWSOM EYES!

Cataract Post-Op Exam

Patient Name: _____ DOB: _____

Surgery Date: OD _____ Surgery Date: OS _____

Progress: _____

_____

UNCORRECTED VISION DISTANCE: OD 20 / _____ NEAR: J _____

OS 20 / _____ J _____

OU 20 / _____ J _____

MANIFEST REFRACTION OD: _____ 20 / _____ ADD _____ J / _____

OS: _____ 20 / _____ ADD _____ J / _____

IOP OD : _____ OS : _____

GTTS:	**DIRECTIONS:**
1. PROLENSA	1 DROP 1 X DAY FOR 3 WEEKS THEN D/C
2. DUREZOL	1 DROP 2 X DAY FOR 2 WEEKS THEN 1 DROP 1 X DAY FOR 2 WEEKS THEN D/C
3. MOXIFLOXACIN	1 DROP 4 X DAY FOR 1 WEEK THEN D/C

OD	SLIT LAMP EXAMINATION	OS
_____	CORNEA	_____
_____	A / C DEEP	_____
_____	IOL CENTERED	_____
_____	PUPIL ROUND	_____
_____	CELLS / FLARE	_____
_____	RETINA ATTACHED	_____

Impression / Instructions : _____

_____

Plan / Follow Up : _____

_____

Co-Managed Optometrist must see the patient for a post-op refraction two weeks after the second eye cataract removal.

_____ _____

CO-MANAGED OD DATE

Please fill out this form and return to NEWSOM EYE by either fax or scan/email.

SEBRING FAX 863-385-1233 TAMPA FAX 813-908-2133

PostOps@newsomeye.net