POSTOPERATIVE REPORT

SISKIYOU EYE CENTER

To: Comanaging Surgeon ☐ **Epstein** ☐ **Ewing**

From: Comanaging Doctor:

Patient: Last _____ **First** _____ **MI** _____

Procedure: ☐ **Cataract / Monofocal IOL** ☐ **Cataract / Toric IOL** **Other** _____
☐ **Cataract / Crystalens** ☐ **Cataract / ReSTOR** ☐ **YAG capsulotomy**

EXAM

OD	**OS**
Exam Date Time Post-op: 1day 1-2 wk 4-5 wks _____ VA: 20/ _____ sc cc PH _____	Exam Date Time Post-op: 1day 1-2 wk 4-5 wks _____ VA: 20/ _____ sc cc PH _____

IOP: OD _____ OS _____

	WNL	**OD**	**OS**
Ext			
Pupil			
Conjunctiva			
Incision			
Cornea			
AC			
Iris			
IOL			
Retina			
Disc			

Refraction

	Sph	**Cyl**	**Axis**	**VA**
OD				
OS				

Plan / Comments:

Medications: ☐Vigamox TID ☐Omnipred TID ☐Nevanac TID Other _____

☐ We will contact surgery scheduler at 541-482-8100 Ashland or 530-842-2760 Yreka to arrange 2nd eye surgery.

☐ Surgeon please contact patient to arrange 2nd eye surgery

2nd Eye ADL (Activity of Daily Living difficulties) _____

Signature _____

Please fax all postoperative exam reports to (Ashland) 541-488-5081 (Yreka) 530-842-5839.

Please contact the surgeon immediately at 541-482-8100 for any medical or surgical concerns.