Post-Operative Report

Patient Name: ____ Date of Birth: ______________ Date of Visit: ______________

Surgeon: ____ Consulting OD: ____

Date of Surgery: ☐ CE / IOL OD ☐ Standard IOL ☐ CE / IOL OS ☐ Standard IOL
☐ Yag OD ☐ Premium IOL ☐ Yag OS ☐ Premium IOL

Post-Operative Day: ☐ OD: 1 2 3 4 5 6 ☐ OS: 1 2 3 4 5 6

Post-Operative Week: ☐ OD: 1 2 3 4 5 6 7 8 9 10 11 12 ☐ OS: 1 2 3 4 5 6 7 8 9 10 11 12

Patient Complaints: ☐ OD: ____ ☐ OS: ____

Current Medications: ____

IOP: OD _______ Uncorrected VA: Refraction:
OS _______ OD 20/ _______ OS 20/ _______ OD ____ 20/ _________
OS ____ 20/ _________

OD			OS		
Cornea:	Clear	☐	Cornea:	Clear	☐
	Edema	☐		Edema	☐
	Other:	☐ ______________________		Other:	☐ ______________________
Anterior Chamber:	Clear	☐	Anterior Chamber:	Clear	☐
	Cells	+1 +2 +3 +4		Cells	+1 +2 +3 +4
Pupil:	Round Irregular		Pupil:	Round Irregular	
Incision:	Seidel: Neg Pos		Incision:	Seidel Neg Pos	
Posterior Capsule:	Clear Hazy		Posterior Capsule:	Clear Hazy	
Implant:	Centered Off-Center		Implant:	Centered Off Center	
Fundus:	Normal ☐		Fundus:	Normal ☐	
	Abnormal: _________________________			Abnormal: __________________________	
	___________________________________			___________________________________	

Plan:

Follow Up: ☐ Routine ☐ Refraction _________ ☐ Days ☐ Weeks ☐ Months with: ☐ OD ☐ Surgeon

Medication: Appointment on: _________________________

Comments:

Signature ____

If any pain, purulent discharge, redness, and/or decrease in vision develops, call our office at 812.424.2020 or 800.489.2020.

Please fax this form to 812.424.3000 or upload it to your "Documents to Talley" folder on our Sharefile site: https://talleyeye.sharefile.com.