TALLEY EYE INSTITUTE

Post-Operative Report

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

Surgeon: _____ Consulting OD: _____

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

Uncorrected VA: OD 20/ _____ OS 20/ _____

Refraction: 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.