1 DAY POST-OP CATARACT

TECH: _____

DOB: **REFERRED BY:**

NAME	**AGE**	**OCULAR MEDS**	**SYSTEM MEDS**
S/P PHACO WITH IOL OD OS	❑ DIABETES	NSAID QD/TID OD OS	
Date of sx	❑ HEART DZ	STEROID TID OD OS	
	❑ HTN		
Premium lens if applicable:	❑ RESPIR		
	❑ THYROID		
CC:	❑ ROS Δ	Review date ____/____/____	
	❑ Social Hist Δ	Review date ____/____/____	

	AR	**IOP**
	OD: _____	OD: TONO APP
	OS: _____	OS: TONO APP
OD: cc sc 20/ J	**RX / REF**	**Dilation:**
OS: cc sc 20/ J	OD: _____	
OU: cc sc 20/ J	OS:	**Dilation Time:**

ORDER ADDITIONAL TESTS:

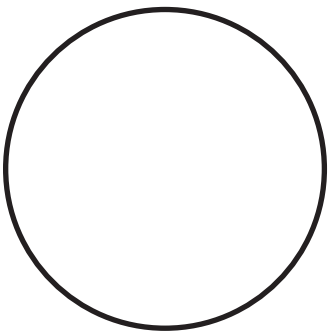
❑ HVF
❑ FA/FP
❑ ANT SEG PHOTO
❑ PAM
❑ BAT
❑ PUPILS
❑ A SCAN
❑ B SCAN

❑ Post-op instructions reviewed by technician

AMSLER GRID:

K L RET ONH

C/D _____

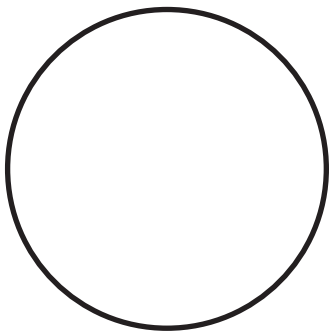


BIO **V90**

	O.D.	**O.S.**
EXT.	❑ NORM	❑ NORM
CONJ.	❑ W&Q	❑ W&Q
CORN	❑ CLEAR	❑ CLEAR
A.C.	❑ D&Q	❑ D&Q
IRIS	❑ WNL	❑ WNL
LENS	❑ CLEAR	❑ CLEAR
	___+NS ___+PSC ___+CS	___+NS ___+PSC ___+CS
IOL	❑ CENTRED IN BAG ❑	
PC	CL _____ + FIBR.	CL _____ +FIBR.
VIT	❑ WNL	❑ WNL
DISC.	❑ WNL	❑ WNL
MAC.	❑ WNL	❑ WNL
VES.	❑ WNL	❑ WNL
PER.	❑ WNL	❑ WNL

K L RET ONH

C/D _____



BIO **V90**

IMP: **S/P PHACO WITH IOL** **OD** **OS**

PLAN: **NO LIFTING OVER 20 LBS**

USE STEROID	**TID**	**OD**	**OS**	CALL ASAP WITH DECREASED VA
USE NSAID	**QD/TID**	**OD**	**OS**	CALL ASAP WITH PAIN

RV O.D. IN	**FOR**	**SIGNATURE**	Date of Service:
RV ECT IN	**FOR**		Faxed: By:

EYE CENTER OF TEXAS
Leaders in Eye Care

Revised 5/2023

DO NOT WRITE BELOW THIS LINE