1 WEEK POST-OP CATARACT
2ND EYE CATARACT EVALUATION

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:**		

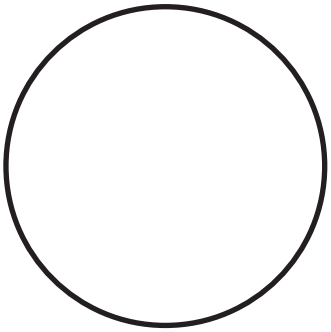
ORDER ADDITIONAL TESTS:

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

❑ Post-op instructions reviewed by technician

K L RET ONH

C/D _____

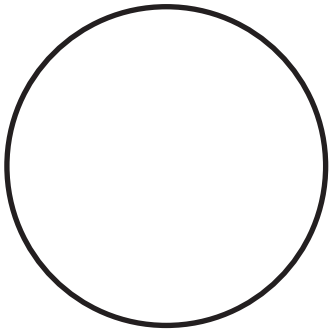


BIO **V90**

	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

L RET ONH

C/D _____



BIO **V90**

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

PLAN: **CONTINUE NSAID AS DIRECTED**
TAPER: STEROID OD OS TID X 1 WEEK, BID X 1 WEEK, QD X 1 WEEK

NO RESTRICTIONS	CALL ASAP WITH DECREASED VA
TREATMENT: PHACO w/IOL OD OS if applicable	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 3/23

DO NOT WRITE BELOW THIS LINE