

# 1 WEEK POST-OP CATARACT/2<sup>nd</sup> EYE CATARACT EVAL

TECH: \_\_\_\_\_

REFERRED BY:

NAME	AGE	OCULAR MEDS:	SYSTEM. MEDS:
S/P PHACO WITH IOL OD OS	<input type="checkbox"/> DIABETES	<b>KETOROLAC</b> TID OD OS	
Date of sx:	<input type="checkbox"/> HEART DZ	<b>BESSIVANCE</b> TID OD OS	
	<input type="checkbox"/> HTN	<b>DUREZOL</b> TID OD OS	
Premium lens if applicable:	<input type="checkbox"/> RESPIR		
	<input type="checkbox"/> THYROID		
CC:	<input type="checkbox"/> ROS Δ	Review date ___/___/___	
	<input type="checkbox"/> Social Hist Δ	Review date ___/___/___	
	<b>AR</b>	<b>IOP</b>	
	OD: _____	OD: TONO APP	
	OS: _____	OS: TONO APP	
OD: cc sc 20/ J	<b>RX / REF</b>	DILATION:	
OS: cc sc 20/ J	OD: _____		
OU: cc sc 20/ J	OS: _____	DILATION TIME:	

<b>ADDITIONAL TESTS:</b> <input type="checkbox"/> HVF <input type="checkbox"/> FA/FP <input type="checkbox"/> ANT SEG PHOTO <input type="checkbox"/> PAM <input type="checkbox"/> BAT <input type="checkbox"/> PUPILS <input type="checkbox"/> A SCAN <input type="checkbox"/> B SCAN	<input type="checkbox"/> <b>Post-op instructions reviewed by technician</b>	<p style="text-align: center;"><u>Second Eye If Applicable</u></p> <p style="text-align: center;">OD <span style="float: right;">OS</span></p> <p>CC: _____</p>
---	---	---

**K L RET ONH**  
C/D \_\_\_\_\_

**BIO** **V90**

<b>EXT.</b> <input type="checkbox"/> NORM <b>CONJ.</b> <input type="checkbox"/> W&Q <b>CORN</b> <input type="checkbox"/> CLEAR <b>A.C.</b> <input type="checkbox"/> D&Q <b>IRIS</b> <input type="checkbox"/> WNL <b>LENS</b> <input type="checkbox"/> CLEAR ___+NS___+PSC___+CS___+NS___+PSC___+CS <b>IOL</b> <input type="checkbox"/> CENTRED IN BAG <input type="checkbox"/> <b>PC</b> CL ___+FIBR. CL ___+FIBR. <b>VIT</b> <input type="checkbox"/> WNL <b>DISC.</b> <input type="checkbox"/> WNL <b>MAC.</b> <input type="checkbox"/> WNL <b>VES.</b> <input type="checkbox"/> WNL <b>PER.</b> <input type="checkbox"/> WNL	<b>OS</b> <input type="checkbox"/> NORM <input type="checkbox"/> W&Q <input type="checkbox"/> CLEAR <input type="checkbox"/> D&Q <input type="checkbox"/> WNL <input type="checkbox"/> CLEAR <input type="checkbox"/> CENTRED IN BAG <input type="checkbox"/> <input type="checkbox"/> WNL <input type="checkbox"/> WNL <input type="checkbox"/> WNL <input type="checkbox"/> WNL
--	--

**K L RET ONH**  
C/D \_\_\_\_\_

**BIO** **V90**

<b>IMP: S/P PHACO WITH IOL OD OS</b>		
<b>PLAN: DC BESSIVANCE OD OS CONTINUE BROMDAY QD OD OS UNTIL BOTTLE IS EMPTY.</b> TAPER: DUREZOL OD OS TID X 2 WEEKS, QD X 1 WEEK		
<b>NO RESTRICTIONS</b>	<b>Bessivance</b> , Begin TID 3 days prior to SX, Continue TID after SX X 1 week <b>Ketorolac</b> , Begin TID 3 days prior to SX, Continue TID after SX until empty <b>Durezol</b> , Begin after surgery TID	
<b>TREATMENT: PHACO w/IOL OD OS if applicable</b>		
RV O.D. IN FOR	<b>SIGNATURE</b>	<b>Date Of Service:</b>
RV ECT IN FOR		<b>Faxed: By:</b>

**DO NOT WRITE BELOW THIS LINE**