

Cataract Surgery Quality Assurance 1 Day Post-op Report



Kindly mail, e-mail or fax your exam findings. Our surgeons rely on this data and we appreciate your help.

Patient's Name _____ DOB _____ Date of Surgery _____

Operative Eye OD OS Date of Exam _____ Pre-op Best Corrected VA 20/ _____

SUBJECTIVE _____

OBJECTIVE

Uncorrected VA

OD 20/ _____

OS 20/ _____

Pinhole VA

OD 20/ _____

OS 20/ _____

IOP air applanation

_____ mm Hg

Conjunctiva injection none 1+ 2+ 3+ 4+

edema none 1+ 2+ 3+ 4+

Wound intact
 leak
 other _____

Cornea epithelial edema none 1+ 2+ 3+ 4+

stromal edema none 1+ 2+ 3+ 4+

AC well formed
 shallow
cells none 1+ 2+ 3+ 4+
 other _____

Pupil round and centered
 other _____

IOL well positioned
 displaced _____ mm
 dislocated

Capsule intact
 opened

ASSESSMENT _____

PLAN _____

Comments _____

Please contact us by telephone if you need assistance with any post-operative condition.

Physician Name _____

Please Print

Signature _____