Cataract Surgery Quality Assurance
1 Day Post-op Report

CATARACT AND LASER INSTITUTE

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 _____ Signature _____
Please Print

Top copy—for your records. Back copy—mail to PCLI. Do not staple.