Cataract Surgery Quality Assurance
4-6 Week Post-op Report

Pacific CATARACT AND LASER INSTITUTE

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

*Items listed in **bold** are data we need. Everything else is optional. If surgery on the second eye is performed within a few weeks of the first, you may include info for both eyes on this form.*

Patient's Name _____ **DOB** _____ **Date of Exam** _____

SUBJECTIVE _____

_____

_____

OBJECTIVE	**RIGHT EYE**	**LEFT EYE**
Date of Surgery		
UCVA Distance	20/ _____	20/ _____
UCVA Near (if multifocal IOL)	J _____	J _____
Manifest Refraction	_____-_____ x _____ 20/ _____	_____-_____ x _____ 20/ _____
Keratometry	_____-_____ @ _____	_____-_____ @ _____
IOP ☐ air ☐ applanation	_____ mm Hg @ _____	_____ mm Hg @ _____
Pupils		
Eyelids		
Conjunctiva		
Surgical wound	☐ intact ☐ other _____	☐ intact ☐ other _____
Cornea (edema)	☐ none ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ other _____	☐ none ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ other _____
AC reaction (cells or flare)	☐ none ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+	☐ none ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
Iris	☐ normal ☐ other _____	☐ normal ☐ other _____
IOL Displacement	☐ none ☐ 1mm ☐ 2mm ☐ 3mm+	☐ none ☐ 1mm ☐ 2mm ☐ 3mm+
IOL Position (if toric IOL)	Axis after dilation _____	Axis after dilation _____
Posterior capsule opacity	☐ none ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ intact ☐ opened YAG date _____	☐ none ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ intact ☐ opened YAG date _____
Vitreous		
Optic Nerve		
Macula	☐ unchanged from pre-op exam ☐ CME other _____	☐ unchanged from pre-op exam ☐ CME other _____
Retina	☐ unchanged from pre-op exam other _____	☐ unchanged from pre-op exam other _____
Other Findings		

ASSESSMENT _____

_____

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_____

PLAN _____

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

Physician Name _____
Please Print

Signature _____

Top copy—for your records. Back copy—mail to PCLI, e-mail to postop@pcli.com, or fax toll-free to 866-924-6718. Do not staple.

01/08