

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



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** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**ASSESSMENT** \_\_\_\_\_ **PLAN** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Physician Name \_\_\_\_\_ Signature \_\_\_\_\_  
Please Print