



Name: _____

DOS: _____

DOB: _____

Referred by: _____

Post-op Co-management Progress Report

Surgery Date _____ Procedure _____ Eye OD OS

Surgeon: Britton Morgan Taylor Post-Op Medication: _____

IOL Type: Monofocal Monovision (____ for reading) Multifocal Accomodative

Date _____

History/Complaint: _____

For Presbyopic-Correcting IOLs

VA_{sc} OD _____
 OS _____
 (Distance) (Intermediate) (Near)

Refraction _____ 20/____ IOP _____ mmHg

SLE: LIDS: Ecchymosis Ptosis Wnl
 Wound: Covered Seidel _____
 Cornea: Edema Striae Clear
 AC: ____ + Cell ____ + Flare
 Pupil: Round Oval Peaked
 IOL: Centered Decentered
 Post Capsule: Clear Wrinkled Cloudy

Impression _____

Plan _____

O.D. Signature _____

Date _____ 1 Week Cyclo Refraction for Crystalens - Surgical Eye Only

Cyclo Ref _____

For Presbyopic-Correcting IOLs

VA_{sc} OD _____
 OS _____
 (Distance) (Intermediate) (Near)

K's OD _____
 OS _____

Refraction OD _____ 20/____
 OS _____ 20/____

IOP OD _____ mmHg
 OS _____ mmHg

SLE: LIDS: Ecchymosis Ptosis Wnl
 Wound: Covered Seidel _____
 Cornea: Edema Striae Clear
 AC: ____ + Cell ____ + Flare
 Pupil: Round Oval Peaked
 IOL: Centered Decentered
 Post Capsule: Clear Wrinkled Cloudy

Fundus: Disc C/D _____
 Macula: Edema Normal Drusen
 Vessels: Normal Tortuous Attenuated
 Periph: Flat
 Comments _____

Impression _____

Plan _____

O.D. Signature _____

NOTE: Transfer of Post-op care is subject to the condition that if the patient develops increased intraocular pressure that is uncontrolled, increased conjunctival hyperemia or exudates, significant lid swelling, loss of vision, increased anterior chamber reaction, hyphema, hypopyon, or excessive pain, that the patient be returned to our care immediately. Thank you very much for your assistance in the care of this patient.
PLEASE FAX THIS TO BVA AFTER EACH POST-OP VISIT. Thank you, BVA.