INSIGHT VISION GROUP

Cataract / YAG / SLT Post Op

Referring Doctor: _____ Today's Date: _____/_____/_____

Date of Surgery: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Surgeon:	Starck Johnson Richard Stewart Carl Tubbs

Fax To:	Parker	303.347.1341
	Boulder	303.593.2199
	Lowry	303.671.2879

OD

Date of Exam: ____/_____/_____ Post-op: 1 day 1 week 1 month 3 month other: _____

Type of IOL: _____ Post Op Goal: _____ Meds: _____-_____

UCVA: 20/____ PH: 20/____ IOP: ____mmHg @_____ am / pm MR:_____ _____ x _____20/_____

Cornea: Incision: Normal Open

Edema: None Trace 1+ 2+ 3+ 4+

Striae: None Trace 1+ 2+ 3+ 4+

Anterior Chamber: Cells/Flare: Clear Trace 1+ 2+ 3+ 4+

Pupil: Round Irregular

IOL: Centered Decentered

Posterior Capsule: Clear_____+ Haze _____+ Wrinkles

Macula: Clear CME other: _____

OS

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Comments:_____

_____

_____.

Dr. Signature: _____