Cataract / YAG Post Op Form

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: ________________________________