OMNI EYE SERVICES POST-OP REPORT FORM

PATIENT'S NAME: ______________________________ DATE: ______________

REFERRING DOCTOR: ______________________________ OMNI SURGEON: ______________________________

CATARACT EXTRACTION O________ (Eye) ____________________ (Date)
O________ (Eye) ____________________ (Date)

PROCEDURE TYPE: ☐ ReStor ☐ Toric ☐ Monofocal ☐ Monovision ☐ LenSx ☐ iStent

CC: ____

TRIMOXI (Check if applies) ☐ Yes ☐ No

ADDITIONAL MEDICATIONS:

Medication	Eye	Frequency	Eye	Frequency
________	O________ Eye	QID TID BID QD (CIRCLE ONE)	O________ Eye	QID TID BID QD (CIRCLE ONE)
________	O________ Eye	QID TID BID QD (CIRCLE ONE)	O________ Eye	QID TID BID QD (CIRCLE ONE)
________	O________ Eye	QID TID BID QD (CIRCLE ONE)	O________ Eye	QID TID BID QD (CIRCLE ONE)

EXAMINATION OF OPERATED EYE

POST-OP VISIT: (CIRCLE ONE)
RIGHT EYE DAY 1 WEEK **1** 2 3 **4** 5 6 7 **8** 9 10 11 12 Other ________
LEFT EYE DAY 1 WEEK **1** 2 3 **4** 5 6 7 **8** 9 10 11 12 Other ________

VA WITHOUT CORRECTION: RIGHT EYE 20/________ PINHOLE 20/________
LEFT EYE 20/________ PINHOLE 20/________

REFRACTION OD ______________________________ VA 20/________
OS ______________________________ VA 20/________

SLIT LAMP EXAM (CIRCLE WITH COMMENTS)

OD

WOUND INTACT ________ SEPARATION ________

CORNEA CLEAR ________ STRIAE ________ EDEMA ________

ANTERIOR CHAMBER 0 1+ 2+ 3+ 4+ CELL/FLARE

IOL STATUS CENTERED ________ DECENTERED ________

POST. CAPSULE CLEAR ________ HAZY ________ WRINKLED ________

MACULA NORMAL ABNORMAL ________

FUNDUS ________________

TENSIONS (APPLANATION) ________ mm Hg at ________ a.m./p.m.

IMPRESSION AND PLAN: ________________

OS

WOUND INTACT ________ SEPARATION ________

CORNEA CLEAR ________ STRIAE ________ EDEMA ________

ANTERIOR CHAMBER 0 1+ 2+ 3+ 4+ CELL/FLARE

IOL STATUS CENTERED ________ DECENTERED ________

POST. CAPSULE CLEAR ________ HAZY ________ WRINKLED ________

MACULA NORMAL ABNORMAL ________

FUNDUS ________________

TENSIONS (APPLANATION) ________ mm Hg at ________ a.m./p.m.

IMPRESSION AND PLAN: ________________

Signature: ______________________________

If any pain and/or decrease in vision develops, an immediate consultation is indicated

TOP COPY REFERRING DOCTORS' RECORD • FOLD BOTTOM COPY AND SEND TO OMNI

RETURN ADDRESS REQUESTED

5505 Peachtree-Dunwoody Road
Suite 300
Atlanta, Georgia 30342-1718