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: ☐ Standard IOL ☐ Toric ☐ PanOptix ☐ Vivity ☐ LenSx
☐ iStent Inject ☐ Hydrus ☐ Xen Stent ☐ OMNI Device ☐ Kahook Goniotomy ☐ Other:_____

CC: _____

MEDICATIONS IF NO TRIMOXI:

_____	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, redness and/or reduced vision develops, an immediate consultation is indicated

FAX REPORT TO: 404-843-8521