OMNI EYE SERVICES

OMNI EYE SERVICES POST-OP REPORT FORM

OMNI EYE SERVICES

PATIENT'S NAME: _____ **DOB:** _____ **DATE:** _____

REFERRING DOCTOR: _____ **OMNI SURGEON:** _____

CATARACT EXTRACTION _____0_____ _____
Eye Date
_____0_____ _____
Eye Date

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

CC: _____

MEDICATIONS:

_____	_____0_____ Eye	_____QID TID BID QD (CIRCLE ONE)	_____0_____ Eye	_____QID TID BID QD (CIRCLE ONE)	
_____	_____0_____ Eye	_____QID TID BID QD (CIRCLE ONE)	_____0_____ Eye	_____QID TID BID QD (CIRCLE ONE)	
_____	_____0_____ Eye	_____QID TID BID QD (CIRCLE ONE)	_____0_____ 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