MILE HIGH EYE INSTITUTE

Patient Name/DOB: _____ Date: _____

Referring Doctor: _____

Date of Surgery: _____

Post-Operative Visit: ____Same-Day ____One-Day ____Week(s) ____ Month(s)

Surgery: Cataract / YAG Capsulotomy / Refractive Lens Exchange / Implantable Contact Lens

OD

Medications:

_____ QID / TID / BID / QD

_____ QID / TID / BID / QD

_____ QID / TID / BID / QD

VA-Dist.: 20/_____ C.F. H.M.

-Near: J_____ @ 16 inches

MR: _____ ▬ _____ ⊠ _____ VA 20/_____

IOP: _____Method: _____

OS

Medications:

_____ QID / TID / BID / QD

_____ QID / TID / BID / QD

_____ QID / TID / BID / QD

VA-Dist.: 20/_____ C.F H.M.

-Near: J _____ @ 16 inches

MR: _____ ▭ _____ ⊠_____ VA 20/_____

IOP: _____ Method:_____

Slit Lamp Exam OD

Lids/Lashes: _____normal _____+ edema

Conjunctiva: _____ clear _____+ injection

Cornea: ____clear ____+Central Edema ____+Periph. Edema

Ant. Chamber: _____D/Q ____+ cell _____+ flare

Pupil: _____round ____irregular ____fixed

IOL: ____P/C ____A/C ____centered ____ decentered

Post. Capsule: ____clear ____+ haze

Anterior Vitreous ____clear ____+ cell ____+ pigment

Macula: _____normal _____ + cystoid edema

Impression and Plan:

Slit Lamp Exam OS

Lids/Lashes: _____normal _____+ edema

Conjunctiva: _____ clear _____+ injection

Cornea: ____clear ____+Central Edema ____+Periph. Edema

Ant. Chamber: _____D/Q ____+ cell _____+ flare

Pupil: _____round ____irregular ____fixed

IOL: ____P/C ____A/C ____centered ____ decentered

Post. Capsule: ____clear ____+ haze

Anterior Vitreous ____clear ____+ cell ____+ pigment

Macula: _____normal _____ + cystoid edema

Impression and Plan:

Doctor's Signature: _____

If any severe pain and/or decrease in vision develops consult Dr. Richheimer (or on call doctor) urgently

Dr. Richheimer's Cell phone: 720-949-5316/Office (on call doctor always available) 303-482-1300