CAVANAUGH EYE CENTER, PA

CATARACT / LENS IMPLANT POST-OP
FAX to: (913) 897-9233

Timothy B. Cavanaugh, MD.

Patient Name: _____ Age: _____ Date: _____ Post-op Visit: _____

Procedure Type: _____ Lens Type:_____ Surgery Date: _____ Co-Manage Dr.:_____@_____

Comments: _____ Meds: _____
_____ _____

VA sc OD 20/ OU 20/ **Int** OD **Near** OD J OU J **IOP** OD _____ mm Hg @_____ am/pm
OS 20/ OS OS J
OS _____ mm Hg

Manifest Rx OD: _____ 20/
OS: _____ 20/

Slit Lamp Examination

OD
Conj: WNL Other_____
Cornea: WNL _____
AC: WNL _____
Lens: WNL _____
Retina: WNL _____

OS
Conj: WNL Other_____
Cornea: WNL _____
AC: WNL _____
Lens: WNL _____
Retina: WNL _____

Impression: _____ **Plan**: _____
_____ _____
_____ _____

RTC: _____ Dictated: Y N Signature: _____Tech_____

Cataract/Lens Implant Post-op Visit

Date: _____ Post-op Visit: _____

Comments: _____ Meds: _____
_____ _____

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_____ _____
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