

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

Timothy B. Cavanaugh, MD.

Patient Name: _____ Age: _____ Date: _____ Post-op Visit: 1 Day 1 Wk 1 Mo

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

Comments: _____ Meds: _____

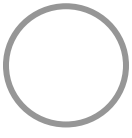
Distance		Intermed	Near			IOP
VA sc OD 20/	OU 20/	OD J	OD J	OU J		OD _____ mm Hg @ _____ am/pm
OS 20/		OS J	OS J			OS _____ mm Hg

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

Slit Lamp Examination

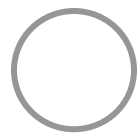
OD **Other**

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



OS **Other**

Conj: WNL _____
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: 1 Day 1 Wk 1 Mo

Comments: _____ Meds: _____

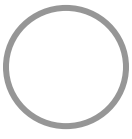
Distance		Intermed	Near			IOP
VA sc OD 20/	OU 20/	OD J	OD J	OU J		OD _____ mm Hg @ _____ am/pm
OS 20/		OS J	OS J			OS _____ mm Hg

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

Slit Lamp Examination

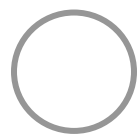
OD **Other**

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



OS **Other**

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



Impression: _____

Plan: _____

RTC: _____ Dictated: Y N

Signature: _____ Tech _____