

# Co-Management Post-Operative Exam Form

For post-op cataract & YAG co-management, please fax to 901-255-5613 or call 901-255-5616.

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Co-Managing Doctor:** \_\_\_\_\_

**Surgery:** Cataract YAG SLT PI **Eye: OD Date:** \_\_\_\_\_ **IOL Type:** \_\_\_\_\_  
 (circle) **Eye: OS Date:** \_\_\_\_\_ **IOL Type:** \_\_\_\_\_

**HPI:** \_\_\_\_\_

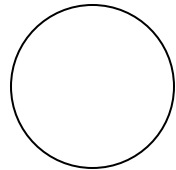
**CC:** \_\_\_\_\_

**Medications:** Prednisolone Acetate / Lotemax / Durezol OD: \_\_\_\_\_ OS: \_\_\_\_\_ **IOP: TAG/PEN** \_\_\_\_\_ am/pm  
 Vigamox / Ciprofloxacin/ Besivance OD: \_\_\_\_\_ OS: \_\_\_\_\_ OD: \_\_\_\_\_ mmHg  
 Ilevro / Ketorolac / Nevanac / Prolensa OD: \_\_\_\_\_ OS: \_\_\_\_\_ OS: \_\_\_\_\_ mmHg  
 Other: \_\_\_\_\_ Dilated OD / OS @ \_\_\_\_\_  
 M .5% / 1% / N 2.5% / C 1%

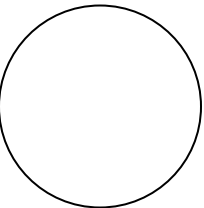
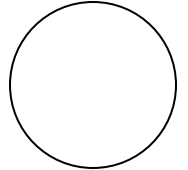
**VA(SC):**

Distance	Intermediate (@ _____)	Near (@ _____)	Refraction	
OD: _____	OD: _____	OD: _____	OD: _____	VA: _____
OS: _____	OS: _____	OS: _____	OS: _____	VA: _____
OU: _____	OU: _____	OU: _____	Add: _____	VA: _____

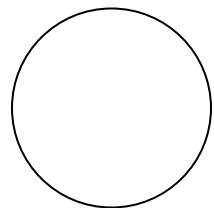
**Slit Lamp Exam:**



\_\_\_\_\_ edema/clear **Cornea** clear/edema \_\_\_\_\_  
 \_\_\_\_\_ Yes/No **Seidel** No/Yes \_\_\_\_\_  
 \_\_\_\_\_ cells/flare/D&Q **A.C.** D&Q/flare/cells \_\_\_\_\_  
 \_\_\_\_\_ irregular pupil/TID/intact **Iris** intact/TID/irregular pupil \_\_\_\_\_  
 \_\_\_\_\_ decentered/centered **IOL** centered/decentered \_\_\_\_\_  
 \_\_\_\_\_ folds/haze/clear **Post Capsule** clear/haze/folds \_\_\_\_\_



\_\_\_\_\_ pallor/pink **ONH** pink/pallor \_\_\_\_\_  
 \_\_\_\_\_ edema/atrophy/drusen/flat **Macula** flat/drusen/atrophy/edema \_\_\_\_\_  
 \_\_\_\_\_ RPE changes/WNL **Periphery** WNL/RPE changes \_\_\_\_\_



**Impression:** \_\_\_\_\_

**Plan:** Prednisolone Acetate 1% / Lotemax / Durezol OD: \_\_\_\_\_ OS: \_\_\_\_\_ Taper: \_\_\_\_\_  
 Vigamox / Besivance / Ciprofloxacin OD: \_\_\_\_\_ OS: \_\_\_\_\_  
 Ilevro / Ketorolac / Nevanac / Prolensa OD: \_\_\_\_\_ OS: \_\_\_\_\_  
 Other: \_\_\_\_\_

- ( ) Limit exertion, Keep water from eye, Shield eye for sleep for 2 weeks
- ( ) Call if Redness, Sensitivity to Light, VA decreases, or Pain (RSVP)

**Return Visit:** Primary Care OD / SEA **In:** \_\_\_\_\_ **on Date:** \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature** **Date** **Faxed on** \_\_\_\_\_ **Dictated on** \_\_\_\_\_

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