Please fax completed form to Alberta Eye MD at 780-461-9430.

CATARACT POST OPERATIVE ASSESSMENT

Name: _____ Date of Exam: _____

Date of Birth: _____ Optometrist: _____

AHC: _____

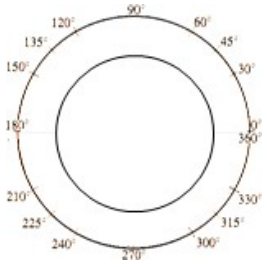
EXAMINATION

V UCVA OD_____ BCVA (PH/MR) OD _____

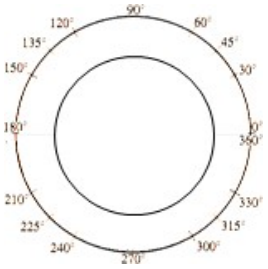
OS _____ OS _____

ANTERIOR SEGMENT OPERATED EYE

☐Lids, lashes, conjunctiva normal OU
☐Iris: normal shape and stroma OU
☐Cornea: _____
☐Lens:_____
☐Anterior chamber:_____



_____Conjunctival Injection_____
_____ Incision_____
_____ Anterior Chamber_____
_____PCIOL_____
Positioning: Centered Yes ___ No ___
_____Toric Alignment in Degrees_____
IOP OD: _____ mmHg
IOP OS: _____ mmHg



FUNDUS EXAMINATION

☐Disc, cup/disc ratio, nerve fiber layer normal ☐Macula normal, good reflex
☐Vasculature normal ☐Peripheral retina normal

For post op day 7 - 21 days please also include:

AR OD _____

AR OS _____

MR OD _____

MR OS _____

If VA is less than 20/40 please include posterior segment examination (description or OCT)

_____

_____

ADDITIONAL NOTES

_____

IMPRESSION: s/p CE + PCIOL OD/OS (Please circle)