CLEAR VISION SURGICAL
KITCHENER-WATERLOO

CATARACT/RLE POST-OPERATIVE FORM

P 226-499-2021 | **F** 226-499-3021

Name _____ Phone _____ D.O.B. Tx: ○ CATARACT ○ RLE

Co-Managing Dr. _____ Dr. Phone _____ Dr. Fax _____ IOL Type: ☐ Monofocal ○ OD ○ OS

☐ Multifocal ○ OD ○ OS

Dr. Email _____ Surgery Date _____ ☐ Toric ○ OD ○ OS

Post-op Visit: ○ 1-2 Weeks ○ 1 Month ○ 3 Months ○ 12 Months ○ Other _____

Meds / Dosage: ☐ Durezol _____ ☐ Zymar _____ ☐ Prolensa _____ ☐ Artificial Tears: ○ PF ○ Regular _____

	OD **Target:** ○ Plano ○ Other _____	**OS** **Target:** ○ Plano ○ Other _____
UCDVA	20 / ○ blurry ○ glare ○ dbl ○ fluctuates	20 / ○ blurry ○ glare ○ dbl ○ fluctuates
UCNVA	20 / ○ blurry ○ glare ○ dbl ○ fluctuates	20 / ○ blurry ○ glare ○ dbl ○ fluctuates
Refraction	_____ 20 /	_____ 20 /
SLIT LAMP	Wound: ☐ Intact _____ Cornea: ☐ Clear _____ AC: ☐ Deep ☐ Quiet _____ Pupil: ☐ Equal ☐ Reactive _____ IOL: ☐ Good Position _____ RR: ☐ Normal _____	Wound: ☐ Intact _____ Cornea: ☐ Clear _____ AC: ☐ Deep ☐ Quiet _____ Pupil: ☐ Equal ☐ Reactive _____ IOL: ☐ Good Position _____ RR: ☐ Normal _____
IOP	_____ mmHg	_____ mmHg

Next followup visit scheduled: _____ ○ day ○ week ○ month ○ year Follow up required with CVS? ○ Y ○ N

Doctor's Comments/Treatment: ○ excellent ○ stable ○ enhancement _____

Quality of Vision: ○ Excellent ○ Acceptable ○ Poor (if poor, please comment) _____

Patient Satisfaction: ○ Satisfied ○ Not Satisfied (if not satisifed, please comment) _____

Comments _____

_____

Dr. Signature _____ Date _____