



POST-OP COMANAGEMENT REPORT

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Date: _____ DOS: _____

Patient Name: _____ DOB: _____ Co-Managing OD: _____

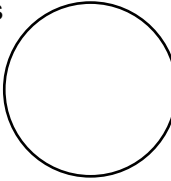
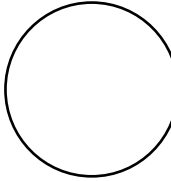
Surgery: _____ Eye(s): OD / OS / OU DOS: _____

Current Eye Meds: _____

Subj: _____

Vasc: _____ Vacc: _____ A/M Refraction: (OD) _____ (OS) _____

Slit Lamp/Fundus Exam: _____ IOP: _____

Lids: nl _____ mm ptosis _____ + swelling _____ + ecchymosis	OD	OS	Iris: nl _____ abnl
Conj: nl _____ + injection _____ scheme _____ bleb			IOL: nl _____ abnl
Wound: nl _____ sut exp _____ + seidel			Lens: nl _____ abnl
Cornea: nl _____ + mce _____ + stromal folds _____ epi defect			Capsule: nl _____ abnl
Ant chamber: nl _____ + cell _____ + flare _____ % shallow			Vitreous: nl _____ abnl
			Retina: nl _____ abnl

Assessment: _____

Plan: _____

ANTIBIOTICS

- ☐ Ocuflox
☐ Ciloxan
☐ Moxifloxacin
☐ Zymaxid
☐ _____
☐ _____

STEROIDS

- ☐ Pred Acetate
☐ Lotemax
☐ Durezol
☐ FML
☐ Alrex
☐ _____

NSAIDS

- ☐ Ketorolac
☐ Prolensa
☐ Nevanac
☐ Diclofenac
☐ Bromfenac
☐ _____

GLAUCOMA

- ☐ Alphagan P
☐ Betimol/Betoptic
☐ Combigan
☐ Latanoprost
☐ Lumigan
☐ _____

OTHER

- ☐ Less drop
☐ AT
☐ Celluvisc
☐ Tobradex
☐ Restasis
☐ _____

Follow up with Dr. _____ in _____ days _____ weeks _____ months _____ years

for: ☐ MRx ☐ New glasses prn ☐ SLE ☐ IOP ☐ 2nd eye refraction goal ☐ Re-check

☐ Other: _____

☐ A follow up appointment has been made for patient to see you.

☐ Please have your office staff contact this patient for the next visit, which will be at your office.

Please Fax to VEA at (920) 380-9323

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