

POSTOPERATIVE EXAM FORM

Patient _____
 Date _____
 Weeks Postop. 3 4 5 6 Final
 (circle week)

Referring Doctor _____
 (Please Print)
 Referring Doctor's
 Signature _____

WOUND	ANT. CHAMBER	LENS IMPLANT	TONOMETRY	REFRACTION	RETINA
Well Closed _____ Other _____ _____ _____	DEEP & QUIET _____ if not, please ✓ below CELLS 1+ Few _____ 2+ Mild _____ 3+ Mod. _____ 4+ Severe _____ FLARE 1+ _____ 2+ _____ 3+ _____ 4+ _____	CENTERED _____ Sketch if not Centered POSTERIOR CAPSULE FIBROSIS 1+ _____ 2+ _____ 3+ _____ 4+ _____	BY APPLANATION _____ mmHg COMMENTS:	OPERATIVE EYE: VA: _____	NORMAL _____ if not normal please ✓ below CME _____ Other _____
CORNEA CLEAR _____ If not, please ✓ below Stromal Edema 1+ _____ 2+ _____ 3+ _____ 4+ _____					