PHYSICIANS
Cincinnati Eye Institute

Cataract Post-Operative Follow-up

Doctor: _____ Surgery Date: _____
(print your name)

Patient Name: _____

Date of Birth: _____ Operative Eye: ☐ OD ☐ OS ☐ OU

CEI Surgeon: _____ Exam Date: _____

Current Eye Drops: _____

OD: $V_a\overline{cmr}$: _____ OS: $V_a\overline{cmr}$: _____

M R.: _____ M R.: _____

IOP: _____ IOP: _____

Exam Findings on Co-Managed Eye

Wound: ☐ Thick ☐ Flat

Conjunctiva: ☐ Quiet ☐ Injected 1+ 2+ 3+

Cornea: ☐ Clear ☐ Trace Thick ☐ Folds 1+ 2+ 3+

Anterior Chamber: ☐ Quiet ☐ Cell 1+ 2+ 3+ 4+ ☐ Flare 1+ 2+ 3+ 4+

Posterior Capsule: ☐ Clear ☐ Mild Haze ☐ Opacification 1+ 2+ 3+ 4+

IOL: ☐ Centered ☐ Displaced

Pupil: ☐ Round ☐ Distorted

Fundus: Macula ☐ Normal ☐ ARMD ☐ CME ☐ ERM

Fundus: Periphery ☐ Normal ☐ Lattice ☐ Tear ☐ Detachment

Comments: _____

PLEASE MAIL OR FAX THIS FORM TO:

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Cincinnati, Ohio 45242
Phone: (513) 984-5133 • Fax: (513) 984-4240

☐ 580 South Loop Road, Suite 200
Edgewood, KY 41017
Phone: (859) 331-9000 • Fax: (513) 984-4240

For CEI office use only:

Reviewed by: _____ _____
Surgeon Name / Signature Date Reviewed