Please return Completed form via email or fax
Email: MyPatient@bostonvision.com
Fax: 617-860-6891

CAT/IOL, CLE/IOL, ICL Post Operative Form

Comanaging Doctor: _____ Contact Person: _____

Patient Name: _____ Appointment Date: _____

Post Op Appointment: Week: _____ Month: _____ Other: _____

Current Medications:

☐ Moxi/ QID: _____ ☐ PF QID/BID: _____ ☐ Ketorolac QID/BID:_____

Other: _____

Complaints:

☐NONE ☐Halos ☐ Dryness ☐ Blurry ☐ Other_____

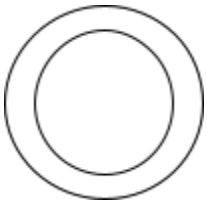
VA (Unaided) **MRX**

OD 20/ PH 20/ OD _____ 20/

OS 20/ PH 20/ OS _____ 20/

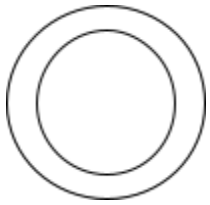
SLE:

OD:



☐ Cornea Clear ☐
☐ Implant Clear ☐
☐ Incision Clear ☐
☐ A/C quiet ☐
☐ PI Patent ☐
(If applicable)

OS:



IOP OD____ OS_____ @_____

Impression:

OD	S/P ☐CAT/IOL ☐CLE/IOL ☐ICL /_____ Condition: _____
OS	S/P ☐CAT/IOL ☐CLE/IOL ☐ICL /_____ Condition: _____

Plan:

☐ PF QID/BID x_____days	☐ OD	☐ OS	☐
☐ Moxi QIDx_____days	☐ OD	☐ OS	☐
☐ Ketorolac QID/BIDx____days	☐ OD	☐ OS	☐
☐ Tears minimum QID	☐ OD	☐ OS	☐
☐ Genteal ung QHS	☐ OD	☐ OS	☐
☐ Other: _____			

DC

Comments: _____

Follow up: _____D/W/M w/ Dr. _____