BLACK HILLS REGIONAL EYE INSTITUTE

Black Hills Regional Eye Institute
2800 Third Street Rapid City, SD 57701
605-341-2000
FAX 605-341-0278

Cataract Post-Op Co-Management Form

Patient Name_____ **DOB**_____ **Date**_____

Referring Doctor _____ **Surgeon** ☐ Bergman ☐ Khachikian ☐ Jorgensen

Surgery Date OD_____ **OS**_____ **Procedure** ☐ Cat. Extract.+ IOL ☐ Phakic IOL ☐ Other:_____

IOL ☐ Single Vision ☐ Monovision (Near OD OS) ☐ Multifocal ☐ Toric ☐ EDOF ☐ LAL

FINDINGS:

Patient Satisfaction ☐ Happy ☐ Unhappy **Comments**_____

Current Eye Meds_____

RIGHT EYE

VAsc (Distance) 20/_____ **VAsc (Near)** 20/_____

MR _____ +/-_____ x _____ 20/_____

IOP _____

SLIT LAMP EXAM:

Wound ☐ Intact _____

Cornea ☐ Clear _____

☐ Axis of LRI Center _____

A/C ☐ D&Q _____

IOL ☐ Centered _____

☐ Axis (If Toric) _____

PC ☐ Clear _____

Macula ☐ Normal _____

Fundus ☐ Normal _____

MEDICATION PLAN:

Med_____ **Dose**_____

Med_____ **Dose**_____

Med_____ **Dose**_____

LEFT EYE

VAsc (Distance) 20/_____ **VAsc (Near)** 20/_____

MR _____ +/-_____ x _____ 20/_____

IOP _____

SLIT LAMP EXAM:

Wound ☐ Intact _____

Cornea ☐ Clear _____

☐ Axis of LRI Center _____

A/C ☐ D&Q _____

IOL ☐ Centered _____

☐ Axis (If Toric) _____

PC ☐ Clear _____

Macula ☐ Normal _____

Fundus ☐ Normal _____

MEDICATION PLAN:

Med_____ **Dose**_____

Med_____ **Dose**_____

Med_____ **Dose**_____

Doctor Comments_____

Eye Institute follow-up with patient recommended ☐ Yes ☐ No

Next Visit_____ **Referring Doctor Signature**_____