

**SHARED CARE
POST-OPERATIVE REPORT**

Surgeon: _____	
DOS: _____	
Operative Eye:	Right _____ Left _____
Primary Eye Care Provider: _____	

Date: _____

Patient: _____

DOB: _____

Current Meds: _____

Allergies: _____

Patient History/Chief Complaint: _____

Va _____ mm Hg
 sc cc _____
Ta _____ mm Hg
 Tonopen @ _____ am pm

M _____ 20/ _____ Add: _____
 _____ 20/ _____ Add: _____

Cornea Yes _____ No _____

Clear _____
 Same as Preop _____

If No	None	Mild	Marked
Edema	_____	_____	_____
Epithelial Defects	_____	_____	_____
Endothelial Deposits	_____	_____	_____

Anterior Chamber

Clear _____
 Deep _____

If No
 Cells _____
 Flare _____
 Hyphema _____

Lids Normal _____
 Wound Secure _____
 Seidel Negative _____
 Capsule Intact _____
 Capsule Clear _____
 IOL Centered _____
 Pupil Round _____

If no, Comments or Observation:

Dilated Fundus Exam: Normal disc, vessels, macula, periphery Other: _____

Recommendations/Medications: See attached medication instruction list

Follow-up visit:

Date: _____

Time: _____

Doctor: _____

Asheville Eye Associates

8 Medical Park Drive
 Asheville, NC 28803
828 - 258 - 6166
877 - EYE - AVLE
393 - 2853
FAX: 828 - 210 - 2681