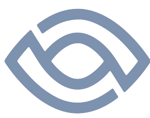

Brimhall eye

Phone: (702) 263-2020 Fax: (702) 396-0287

Pt Name:		Optometry Clinic:
Date:	**Post –Operative Note**	Provider:

Chief Complaint

S/p **Cataract Surgery / LASIK / ASA**, post-op week ______ **OD / OS / OU.**

Uncorrected Vision

	OD		OS	
	Distance	20/	Distance	20/

Refraction

OD				OS			
Sph	Cyl	Axis	BCVA	Sph	Cyl	Axis	BCVA
			20 /				20 /

Intraocular Pressure

OD:	mmHg	OS:	mmHg

Slit Lamp Exam

	OD	OS
L/L/L:	☐ WNL	☐ WNL
Scl/Conj:	☐ Quiet	☐ Quiet
Cornea:	☐ Clear	☐ Clear
A/C:	☐ D+Q	☐ D+Q
Iris:	☐ WNL	☐ WNL
Lens:	☐ PCIOL	☐ PCIOL
Ant Vit:	☐ Quiet	☐ Quiet
Disc:	☐ WNL	☐ WNL
Macula:	☐ WNL	☐ WNL
Vessels:	☐ WNL	☐ WNL
Periph:	☐ No Holes	☐ No Holes

Impression

S/p surgery as per above.

Plan

Provider Signature: ___________________________