



OMNI EYE SERVICES POST-OP REPORT FORM



PATIENT'S NAME: _____ DATE: _____

REFERRING DOCTOR: _____ OMNI SURGEON: _____

CATARACT EXTRACTION ☐ _____ Eye _____ Date _____
☐ _____ Eye _____ Date _____

PROCEDURE TYPE: ☐ Standard IOL ☐ Toric ☐ PanOptix ☐ Vivity ☐ LenSx
☐ iStent Inject ☐ Hydrus ☐ Xen Stent ☐ OMNI Device ☐ Kahook Goniotomy ☐ Other: _____

CC: _____

MEDICATIONS IF NO TRIMOXI: _____ ☐ _____ QID TID BID QD ☐ _____ QID TID BID QD
Eye (CIRCLE ONE) Eye (CIRCLE ONE)
_____ ☐ _____ QID TID BID QD ☐ _____ QID TID BID QD
Eye (CIRCLE ONE) Eye (CIRCLE ONE)
_____ ☐ _____ QID TID BID QD ☐ _____ QID TID BID QD
Eye (CIRCLE ONE) Eye (CIRCLE ONE)

EXAMINATION OF OPERATED EYE

POST-OP VISIT: RIGHT EYE DAY 1 WEEK 1 2 3 4 5 6 7 8 9 10 11 12 Other _____
(CIRCLE ONE)

LEFT EYE DAY 1 WEEK 1 2 3 4 5 6 7 8 9 10 11 12 Other _____

VA WITHOUT CORRECTION: RIGHT EYE 20/ _____ PINHOLE 20/ _____
LEFT EYE 20/ _____ PINHOLE 20/ _____

REFRACTION OD _____ VA 20/ _____
OS _____ VA 20/ _____

SLIT LAMP EXAM (CIRCLE WITH COMMENTS)

OD

WOUND INTACT _____ SEPARATION _____
CORNEA CLEAR _____ STRIAE _____ EDEMA _____
ANTERIOR CHAMBER 0 1+ 2+ 3+ 4+ CELL/FLARE
IOL STATUS CENTERED _____ DECENTERED _____
POST. CAPSULE CLEAR _____ HAZY _____ WRINKLED _____
MACULA NORMAL ABNORMAL _____
FUNDUS _____
TENSIONS (APPLANATION) _____ mm Hg at _____ a.m./
p.m.
IMPRESSION AND PLAN: _____

OS

WOUND INTACT _____ SEPARATION _____
CORNEA CLEAR _____ STRIAE _____ EDEMA _____
ANTERIOR CHAMBER 0 1+ 2+ 3+ 4+ CELL/FLARE
IOL STATUS CENTERED _____ DECENTERED _____
POST. CAPSULE CLEAR _____ HAZY _____ WRINKLED _____
MACULA NORMAL ABNORMAL _____
FUNDUS _____
TENSIONS (APPLANATION) _____ mm Hg at _____ a.m./
p.m.
IMPRESSION AND PLAN: _____

Signature: _____

If any pain, redness and/or reduced vision develops, an immediate consultation is indicated

FAX REPORT TO: 404-843-8521