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POST-OPERATIVE PROGRESS REPORT

Patient's Name: _____ Date: _____

☐ **Cataract Extraction with IOL** ☐ **Crystalens** ☐ **Toric** ☐ **Laser**

CC: _____

_____

MEDICATIONS:	**OD**	**OS**	**OU**

EXAMINATION OF THE OPERATIVE EYE

VA without correction 20/_____ Pinhole 20/_____ Tap@ _____: OD _____/ OS_____

Slit Lamp Exam: OD _____

OS _____

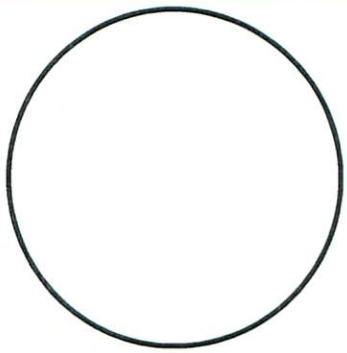
Wound: Intact/Separation

Cornea: Clear/Edema _____

A/C: 0 +1 +2 +3 +4 Cell/Flare

IOL Status: Centered/Decentered

Capsule: Clear/Hazy



Impression: _____

Plan: _____

Follow-up: _____ Signature: _____

[ ] Progress Report faxed to Akler Eye Center 313.563.3930 Date: _____

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Patient Name: _____

POST-OPERATIVE SCHEDULE
Please **Read** Carefully

MEDICATION SCHEDULE

You will be using one eye drop beginning the day of your surgery.

Prolensa/Ilevro- 1 drop once a day in the operative eye for 14 days.

POST-OPERATIVE ACTIVITIES

You have had no-stitch cataract surgery. You may usually resume your normal activities almost immediately with the exception of the following: no heavy lifting (over 50 pounds), no continuous bending, and no swimming for the first week following your surgery. You may drive yourself to your one day post-op appointment. However, remember you have a "new" eye and it may take you a while to adjust. Your vision may be blurry. If you have any questions about other activities, please feel free to ask your co-managing doctor or Dr. Akler.

POST-OPERATIVE CARE

Dr. Akler will see you for your one day post-op visit, then you will be released back to for your remaining post-op visits to be sure your eye is healing properly. Your eye doctor will see you over the next several months as he or she feels necessary to monitor your progress. Usually by your three week post-op visit you are ready to get a new prescription for glasses. Approximately six months after your surgery is completed, it is important to have a re-examination to ensure that you have healed completely and normally.

If you encounter any pain or sudden change in your vision in your operated eye, contact your doctor or Dr. Akler immediately at 313.563.3937.

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2841 Monroe Street, Suite 1
Dearborn, MI 48124
T 313.563.EYES (3937)
F 313.563.3930

CONSENT FOR COMANAGEMENT AFTER CATARACT SURGERY

Patient Name: _____ Date: _____

Dr. Michelle Akler will be performing _____ on my Right/Left eye. It is my desire to have _____ perform my postoperative follow-up care. I understand that _____ will contact Dr. Akler immediately if I experience any complications related to my Cataract surgery. I also understand that I may contact Dr. Akler at any time after the surgery.

Patient: _____ Date: _____

Witness: _____ Date: _____

OPTOMETRIST CONFIRMATION

I have agreed to provide follow-up care on _____. I will see the patient after cataract surgery when Dr. Akler notifies me that she is releasing the patient to my care.

I agree to notify Dr. Akler immediately should any complications arise and to provide her with written progress reports during my portion of the postoperative period.

Physician Signature: _____ Date: _____