

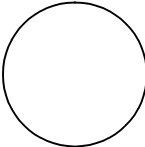
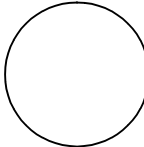
# ALFRED HOSPITAL Optometrist Cataract Surgery After-Care Report

**Fax to 9076 2709** U. R. .... Date Aftercare Performed ...../...../.....

Patient Surname..... Given Name(s) .....

Address .....D.O.B...../...../..... Ph.....

.....P'code.....Mob.....

Report Item	Normal Findings (Mark 'X' Circle or PRINT)	Abnormal Findings & Additional Details (Mark 'X', Circle or Print in BLOCK CAPITALS) ANY FINDING AS SHOWN IN BOLD CAPITALS REQUIRE IMMEDIATE PATIENT RETURN TO THE ALFRED - RING *Ph 9076 2000* ask for EYE REGISTRAR
EYE	R <input type="checkbox"/> L <input type="checkbox"/> → → →	Date cataract surgery performed R L
This visit Post Op	.....Days .....Weeks	<input type="checkbox"/> Unscheduled - Reason for Visit : Other:
Subjective	Eye Comfortable <input type="checkbox"/>	<input type="checkbox"/> Pain – <input type="checkbox"/> scratchy <input type="checkbox"/> SHARP PERSISTENT <input type="checkbox"/> ACHE <input type="checkbox"/> BORING <input type="checkbox"/> Floaters <input type="checkbox"/> FREQUENT PHOTOPSIA <input type="checkbox"/> PHOTOPHOBIA Other:
Vision	Unaided Pin Hole R 6/..... R 6/..... L 6/..... L 6/.....	Refraction & Best Corrected Acuties Rx R 6/..... L 6/..... Add +
Keratometry	_____ x _____ x	<input type="checkbox"/> Mires Distorted - <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> SEVERE Other:
Wound	Sound <input type="checkbox"/> (Seidel -ve)	<input type="checkbox"/> GAPE <input type="checkbox"/> LEAK (+VE SEIDEL) <input type="checkbox"/> INFILTRATES Other:
Cornea	NAD or minor SPK <input type="checkbox"/>	<input type="checkbox"/> BULLOUS OEDEMA Other:
Anterior Chamber	Quiet <input type="checkbox"/> <input type="checkbox"/> Cells Grade I (trace) <input type="checkbox"/> Flare Grade I (trace)	<input type="checkbox"/> CELLS GRADE <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> HYPOPYON <input type="checkbox"/> FLARE GRADE <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> HAEMORRHAGE <input type="checkbox"/> VISCOELASTIC <input type="checkbox"/> PUPIL BLOCK Other:
IOL	Stable <input type="checkbox"/>	<input type="checkbox"/> Decentration <input type="checkbox"/> Tilt <input type="checkbox"/> PUPIL CAPTURE <input type="checkbox"/> SUBLUXATION Other:
IOP	R Time : L	<input type="checkbox"/> ONE EYE ≥ 28MMHG
Topical Meds	Reviewed <input type="checkbox"/> Compliant <input type="checkbox"/> → → →	Ocular Medication instructions to Px: <input type="checkbox"/> Patient advised on topical steroids - discontinue* Yes <input type="checkbox"/> NO <input type="checkbox"/> (* discontinue steroids if no complications at 21 day post-op after-care)
Next Visit	Ophthalmologist <input type="checkbox"/> Optometrist <input type="checkbox"/>	Scheduled:
Other relevant details/findings/actions/Instructions to Patient		Sketch Findings <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  R         </div> <div style="text-align: center;">  L         </div> </div>

**For queries on findings or immediate patient return → ring Alfred ask for Eye Registrar on 9076 2000**

Optometrist (Print) .....

Signature ..... Provider No.....

Practice Name.....

Address.....

.....P'Code.....

Ph ..... Fax.....

(practice stamp - include Fax No.)