



43309 US 19 N • Tarpon Springs, FL 34689
 1-800-282-9905 • FAX 727-943-3108

Post-Operative Cataract Surgery Co-Management Form

Date: _____

Co-Managing Doctor _____ Fax Number _____

Patient Name _____ D.O.B. _____

St. Luke's Chart # _____

To Surgeon: James P. Gills, MD Pit Gills, MD

IOL Type: Monofocal Toric Presbyopic

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RE

LE

Date of Post-Op _____	Post Operative Evaluation			
VA sc _____ / _____ Near VA 33" _____	16"	VA sc _____ / _____ Near VA 33" _____	16"	
K reading _____		K reading _____		
Refraction _____ VA _____ IOP _____		Refraction _____ VA _____ IOP _____		
Photostress _____ Rose _____		Photostress _____ Rose _____		
Cornea				
<input type="checkbox"/> Clear		<input type="checkbox"/> Clear		
<input type="checkbox"/> Wound Intact		<input type="checkbox"/> Wound Intact		
Anterior Chamber				
<input type="checkbox"/> Deep / Quiet		<input type="checkbox"/> Deep / Quiet		
Lens				
<input type="checkbox"/> Lens in Place		<input type="checkbox"/> Lens in Place		
<input type="checkbox"/> Capsule Intact		<input type="checkbox"/> Capsule Intact		
Fundus				
<input type="checkbox"/> As Documented Preop		<input type="checkbox"/> As Documented Preop		

Medication	Follow-Up
<input type="checkbox"/> Zymar	<input type="checkbox"/> Artificial Tears _____ Notes: _____
<input type="checkbox"/> Pred Forte _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Acular _____	<input type="checkbox"/> Other _____

Next Visit

RE

LE

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