GRAND RAPIDS OPHTHALMOLOGY
Eye Care | Surgery | Laser Correction

CATARACT/IMPLANT POST-OPERATIVE FORM

Surgeon requires best corrected vision within 90 days of surgery for the MACRA/MIPS reporting.
*Use this form at the conclusion of post operative period **or send a completed chart note.**

I have agreed to accept transfer of care for this patient.

Patient Name: _____ D.O.B.: _____ Phone: _____

Surgeon_____Date _____

Surgery Date_____ Follow up Date_____

Co-Managing Doctor_____ Surgery Location _____

Procedure □ Standard IOL □ Toric □ Multifocal □ ICL □ Other _____

OD OS □ 1 Day □1 Week □1 Month □ 3 Months □ 6 Months

Current Meds:

_____

Subjective Findings:

_____

_____

(Include slit lamp and dilated fundus as needed.)

Assessment	OD	OS
VA sc	D 20/_____ I 20/_____Near_____	D 20/____ I 20/____ Near_____
Refraction	_____20/_____	_____20/_____
Keratometry	_____/_____@_____	_____/_____@_____
Lens	□ Clear ◯ □ Other _____ _____	□ Clear ◯ □ Other _____ _____
Intraocular Pressure circle: NCT / Goldman / Tonopen	_____mm/Hg	_____mm/Hg

Impression on presbyopia correction _____

Impression/comments_____

Plan_____ Next Visit_____

Doctor Signature_____ Date_____

Fax Completed Form to Surgeon's office at: 616-365-1130

4/16/24