



**Black Hills Regional Eye Institute Cataract Co-Management Form**  
 Please fax form to 605-341-0278

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Surgeon  Nixon  Hafner  Khachikian  Spencer

Surgery Date OD \_\_\_\_\_ OS \_\_\_\_\_ Procedure  Cat. Extract.+ IOL  Phakic IOL  LRI  Other: \_\_\_\_\_

IOL  Single Vision  Monovision (Near OD OS)  Multifocal  Accommodating  Toric

**FINDINGS:**

Patient Satisfaction  Happy  Unhappy Comments \_\_\_\_\_

Current Eye Meds \_\_\_\_\_

Distance VASC OU \_\_\_\_\_

Intermediate VASC OU \_\_\_\_\_

Near VASC OU \_\_\_\_\_

**RIGHT EYE**

VAsc Distance 20/ \_\_\_\_\_ VAsc Near 20/ \_\_\_\_\_

VAsc Intermediate (Arms Length) 20/ \_\_\_\_\_

MR \_\_\_\_\_ +/- \_\_\_\_\_ x \_\_\_\_\_ 20/ \_\_\_\_\_

IOP \_\_\_\_\_

**SLIT LAMP EXAM:**

Wound  Intact \_\_\_\_\_

Cornea  Clear \_\_\_\_\_

Axis of LRI Center \_\_\_\_\_

A/C  D&Q \_\_\_\_\_

IOL  Centered \_\_\_\_\_

Axis (If Toric) \_\_\_\_\_

PC  Clear \_\_\_\_\_

Macula  Normal \_\_\_\_\_

Fundus  Normal \_\_\_\_\_

**MEDICATION PLAN:**

Med \_\_\_\_\_ Dose \_\_\_\_\_

Med \_\_\_\_\_ Dose \_\_\_\_\_

Doctor Comments \_\_\_\_\_

Eye Institute follow-up with patient recommended  Yes  No

Next Visit \_\_\_\_\_ Referring Doctor Signature \_\_\_\_\_

**LEFT EYE**

VAsc Distance 20/ \_\_\_\_\_ VAsc Near 20/ \_\_\_\_\_

VAsc Intermediate (Arms Length) 20/ \_\_\_\_\_

MR \_\_\_\_\_ +/- \_\_\_\_\_ x \_\_\_\_\_ 20/ \_\_\_\_\_

IOP \_\_\_\_\_

**SLIT LAMP EXAM:**

Wound  Intact \_\_\_\_\_

Cornea  Clear \_\_\_\_\_

Axis of LRI Center \_\_\_\_\_

A/C  D&Q \_\_\_\_\_

IOL  Centered \_\_\_\_\_

Axis (If Toric) \_\_\_\_\_

PC  Clear \_\_\_\_\_

Macula  Normal \_\_\_\_\_

Fundus  Normal \_\_\_\_\_

**MEDICATION PLAN:**

Med \_\_\_\_\_ Dose \_\_\_\_\_

Med \_\_\_\_\_ Dose \_\_\_\_\_