

# CK Surgery Co-Management Exam Form

SEA Record of Medical Care



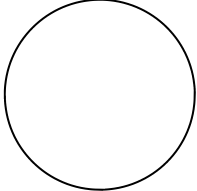
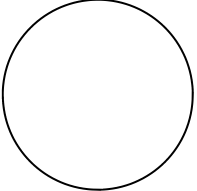
Patient's Name: \_\_\_\_\_ Tech: \_\_\_\_\_ Page#: \_\_\_\_\_

CK Post-Op: \_\_\_\_\_ OD / OS / OU Treatment Date: \_\_\_\_\_

Patient Requires Reading Glasses for:  Magazine  Newspaper  Price Tag  Computer  Book  
 Med. Label  Menu  Watch  Caller ID  Other \_\_\_\_\_

Comments: \_\_\_\_\_

Ocular Medications: \_\_\_\_\_

OD	VA SC	OS
20/_____ Distance	Distance 20/_____ OU	Distance 20/_____
20/_____ Near	Near 20/_____ OU	Near 20/_____
20/_____ OD	<b>MR</b>	OS _____ 20/_____
_____ Atch OD	<b>TOPO</b>	OS Atch _____
Clear _____ @ _____ OD	<b>K's</b>	OS _____ @ _____ Clear
Distorted _____ @ _____ OD		OS _____ @ _____ Distorted
@ _____ am / pm _____ mmHg PEN / TAG OD	<b>IOP</b>	OS TAG / PEN _____ mmHg @ _____ am / pm
Bandage CL? <input type="checkbox"/> YES <input type="checkbox"/> NO		Bandage CL? <input type="checkbox"/> YES <input type="checkbox"/> NO
		
_____ Other / 32 / 24 / 16 / 8 OD	<b>SPOTS</b>	OS 8 / 16 / 24 / 32 / Other _____
_____ Edema / Haze / Clear OD	<b>CLARITY</b>	OS Clear / Haze / Edema _____
_____ SPK / Irregular / Intact OD	<b>EPITHELIUM</b>	OS Intact / Irregular / SPK _____

### IMPRESSION

### PLAN

Patient Satisfaction: Happy?  YES  NO Unhappy?  YES  NO Reassured?  YES  NO

Eye Care Provided By: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Please Fax to Southern Eye Associates at (901) 255-5612**