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

Date__________________

Patient Name____ Date of Birth __________________________

Referring Doctor _________________________ **Surgeon** Nixon Hafner Khachikian Zimmerman

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_________________

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_________________

Doctor Comments____

Eye Institute follow-up with patient recommended Yes No

Next Visit_________________________________ Referring Doctor Signature__________________________________