

**Date:** [Insert Date]

**Patient Name:** [Insert Patient Name]

**Date of Birth:** [Insert DOB]

**Medical Record Number:** [Insert MRN]

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## Discharge Summary: Cataract Surgery

**Procedure:** Phacoemulsification and Intraocular Lens (IOL) Implantation

**Eye Operated:** [Left Eye / Right Eye / Both]

**Surgeon:** Dr. [Insert Surgeon Name]

### Post-Operative Instructions

- **Eye Shield:** Wear the protective eye shield while sleeping for the first [Insert Number] nights to prevent accidental rubbing.
- **Activity:** Avoid strenuous exercise, heavy lifting (over 10 lbs), and bending at the waist for [Insert Number] week(s).
- **Hygiene:** Do not get water, soap, or shampoo directly in the operated eye for [Insert Number] days. Do not swim or use hot tubs for [Insert Number] weeks.
- **Protection:** Wear sunglasses outdoors to protect the eye from bright light and dust.

### Medication Schedule (Eye Drops)

Medication Name	Dosage	Frequency	Duration
[Antibiotic Drop]	1 Drop	[X] times per day	[X] days
[Anti-inflammatory Drop]	1 Drop	[X] times per day	[X] weeks

### Follow-Up Appointment

Your follow-up appointment is scheduled for:

**Date:** [Insert Date]

**Time:** [Insert Time]

**Location:** [Insert Clinic Address]

# When to Call the Doctor Immediately

Please contact the clinic or emergency services if you experience:

- Sudden or severe eye pain.
- Significant decrease in vision or sudden "curtain" over your vision.
- Increased redness or swelling of the eyelid.
- Excessive discharge or pus from the eye.
- New flashes of light or a sudden increase in floaters.

**Emergency Contact Number:** [Insert Phone Number]

Signed,

[Doctor Signature/Name]

[Department Name]