

Date: [Date]

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

DISCHARGE SUMMARY: Cataract Extraction and Vision Correction

Procedure Date: [Date of Surgery]

Operative Eye: [Left / Right / Both]

Surgeon: [Surgeon Name]

Intraocular Lens (IOL) Type: [Lens Model/Power]

1. Procedure Overview

The patient underwent elective phacoemulsification with intraocular lens implantation. The procedure was completed without complications. Local anesthesia and sedation were administered as recorded in the operative report.

2. Post-Operative Medications

- **Antibiotic Drops:** [Name], [Frequency] for [Duration].
- **Anti-inflammatory Drops:** [Name], [Frequency] for [Duration].
- **Pain Relief:** [Name/OTC recommendation] as needed for mild discomfort.

3. Activity Restrictions

- Do not rub or press on the operated eye.
- Wear the provided eye shield while sleeping for the first [Number] nights.
- Avoid heavy lifting (over 10 lbs) and strenuous exercise for [Number] weeks.
- Avoid swimming or getting soapy water directly in the eye for [Number] days.

4. Follow-Up Appointments

First Post-Op Visit: [Date and Time] at [Location].

5. Warning Signs

Please contact the clinic or seek emergency care immediately if you experience:

- Sudden or severe decrease in vision.
- Severe eye pain not relieved by medication.
- Increased redness or excessive discharge.
- New flashes of light or a sudden increase in floaters.

Physician Signature: _____

Facility Name: [Clinic/Hospital Name]

Contact Number: [Phone Number]