

Ophthalmology – Sample Note, Phacoemulsification

Patient Name: Jeffrey Rogers
MRN: 4555
Note Status: Finalized

Procedure Date: 01/30/2011 10:00:00
Account #: 22233
Attending MD: Thomas C. Paine MD

Providers:

Thomas C. Paine, MD (Doctor)

Referring MD:

James Edwards, MD

Procedure:

Phacoemulsification With Intraocular Lens Implant, Right Eye

Pre-OP Diagnosis:

Cataract

Post-OP Diagnosis:

Cataract

Patient Profile:

The patient is a 48 year old male. Refer to note in patient chart for documentation of history and physical. Due to the nature of the patient's increasing symptoms, surgery is recommended. The alternatives, risks and benefits of surgery including eye injury, including visual loss were discussed with the patient. The patient verbalized understanding of the risks as well as the alternatives to surgery. The patient wished to proceed with operative intervention. A signed and witnessed informed consent was placed on the chart.

Anesthesia:

Topical - lidocaine 2% Solution

Complications:

No Immediate Complications.

Operative Parameters:

Prep and Drape:

- A topical anesthetic, lidocaine gel 2%, administered every 10 minutes, for an hour was applied to the ocular surface of the operative eye. The patient was prepped and draped in the usual sterile fashion. A lid speculum was placed in the operative eye and the microscope was moved into position.

Procedure Details:

- A 3.0 mm clear corneal incision was made at the 12 o'clock position.
- 0.5% Lidocaine was injected into the anterior chamber. Healon was placed in the clear corneal incision.
- A side port was made at the 2 o'clock position.
- Three relaxing incisions were made at the 90 degree axis.
- Using a 25 gauge bent needle, a 360 degree anterior capsulorhexis was performed to remove part of the anterior lens capsule.
- The lens was hydrodissected and hydrodelimited using a balanced salt solution.
- Phacoemulsification and extraction of the nucleus were performed using a divide and conquer technique. The residual cortical material was removed using irrigation and aspiration. The posterior capsule was intact.
- Healon was used to inflate the capsular bag. The posterior chamber lens implant was inspected and irrigated. The implant was then placed in the capsular bag using a Mastel injector. The implant was then unfolded and positioned with a Sinsky hook. The implant showed good position and stability. The ophthalmic viscosurgical device was completely removed using the irrigation/aspiration device. The anterior chamber was reformed using a balanced salt solution.

Closure:

- No suture was applied. The incision was found to be water tight. Ancef, Celestone and Tobramycin were injected subconjunctivally. Bacitracin ointment and Pilopine gel were given postoperatively. The lid speculum was removed. The eye was then covered with a shield.

Post-OP Plan:

DISCHARGE INSTRUCTIONS:

- Activity:

* May return to work in 2 days with the following restrictions: no lifting over 5 lbs. or heavy straining, no sport activities and no swimming for 10 days.

- Follow-Up:

* With Ophthalmologist in 10 days.

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CPT© Code(s):

66984, RT, Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

ICD9 Code(s):

366.9, Unspecified cataract

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E-Signed by: Thomas C. Paine, MD

Thomas C. Paine, MD
Signed Date: 01/30/2011 10:35:08
Number of Addenda: 0
This report has been signed electronically.
Note initiated on 01/30/2011 10:00:00