# Materials for Item No. 5

January 12, 2026

[Licensee 1] O.D.
c/o Casey Tyler, Esq.
Hall Prangle, LLC
1140 North Town Center Dr., Ste. 350
Las Vegas, NV 89144
ctyler@hallprangle.com
netienne@hallprangle.com
*via email only*

Re: NSBO Complaint# 26-13
Patient: [the patient]

Dear Licensee:

This office has been apprised of allegations that your care and treatment of the above-referenced patient may have been unprofessional as defined in Nevada Revised Statute (NRS) 636.295 and Nevada Administrative Code (NAC) 636.230 alleging:

On or about June 11, 2024, ophthalmologist [OMD 1] performed cataracts surgery upon the patient's right eye. [OMD 1]'s operative report documented placement of a bandage contact lens (BCL). On or about June 12, 2024, the patient presented to you for his first post-operative follow-up. You allegedly breached the standard of care by:

Failing to review Plaintiff's operative report and surgical records before providing care;
Failing perform adequate examinations that would have revealed the retained contact lens;
Failure to recognize, document, or address the BCL presence during multiple examinations over 4+ months;
Failing to correlate Plaintiff's ongoing complaints of discomfort and vision issues with potential retained device;
Failing to communicate with the operating surgeon regarding post-operative course and concerns;
Continuing to perform procedures (YAG laser) without ensuring complete knowledge of eye condition; and

Failing to maintain appropriate post-operative communication protocols.

This letter is issued pursuant to R66-19(14)(2) mandating the Executive Director to conduct any investigation he or she determines is necessary to ascertain the facts concerning the incident described in the report without limitation requiring the licensee to provide information concerning the incident. You are hereby requested to submit a written response as to the allegations. Please include any and all information you believe would be useful for the Board to make a determination in this matter.

If not already included in your response to the above-listed allegations/alleged failures, ensure your response includes an explanation as to the following:

1) Did you see the BCL? If not, why not?
2) Did you document the BCL? If not, why not?
3) Did you remove the BCL? If not, why not?
4) Did you receive instructions from [OMD 1] about how to manage the BCL and did you follow such instructions? If you did not receive any such instructions about the BCL: a) how did you decide to not remove the BCL?; b) did you manage the patient any differently compared to a post-op patient without a BCL? If so, how so?
5) How did you decide on exactly a 6-day follow-up with this patient? Is that your custom and practice for post-operative patients similar to this patient? Or was that based upon your knowledge of the BCL?
6) Did you provide any instructions to or discuss with [OMD 2] your plans, be it a recommendation to remove the BCL versus continue with [OMD 1]'s plans? If not, why not?
7) Did you review [OMD 1]'s operative report by the time you rendered care to the patient on or about June 12, 2024? If not, why not?
8) Were you notified of any surgical complications as to why the BCL was placed and that you were supposed to monitor the BCL? If not, did you inquire of [OMD 1] about any surgical complications or usage of the BCL?
9) Did you review the post-operative medication schedule, more specifically the use of antibiotic eye drops (if applicable)? If not, why not?
10) Was your conduct unprofessional as defined by as defined in Nevada Revised Statute (NRS) 636.295 and Nevada Administrative Code (NAC) 636.230? If not, why not?

**Failure to responsively address each of the above allegations could result in a determination that you agree with the above allegations/alleged failures.** Your reply to director@nvoptometry.org is due on or by the close of business **February 12, 2026**.

**Because this matter may be presented to the Board in a double-blind manner, in your response do NOT use your personal or company letterhead, and use the following references: [The patient] as "the patient," yourself as "Licensee 1," [Practice Entity 1] as "Practice Entity 1," [OMD 1] as "OMD 1" and [OMD 2] as "OMD 2."**

The Nevada State Board of Optometry investigates all information received concerning possible violations of NRS/NAC 636. This letter is not to be construed as a determination as to whether or not there has been a violation of such laws until a thorough investigation is completed. The accompanying subpoena is sent pursuant to NRS 636.141 and NRS 629.061(1)(g). As a licensee subject to an investigation, you are required by law to timely provide the requested information.

Please be advised that if any particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the law, specifically including but not limited to NRS 636.295(8)(unprofessional conduct in the practice of optometry).

Respectfully,

*/s/ Adam Schneider*
Adam Schneider, Esq.
Executive Director

HALL PRANGLE LLC

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Marie Ellerton
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April 30, 2026

**VIA U.S. Mail and EMAIL** director@nvoptometry.org

Adam Schneider, Esq.
Executive Director
NEVADA STATE BOARD OF OPTOMETRY
PO Box 1824
Carson City, Nevada 89702

**“LICENSEE 1’S” RESPONSE TO THE NEVADA STATE BOARD OF OPTOMETRY’S CORRESPONDENCE RE: NSBO COMPLAINT # 26-13, THE PATIENT**

Dear Mr. Schneider:

This correspondence is intended to serve as Licensee 1’s formal response to the January 12, 2026, letter from the Nevada State Board of Optometry (“Board”) regarding Complaint # 26-13, related to The Patient. This response is timely submitted.

In its letter the Board indicates that it has been apprised of allegations that Licensee 1’s care and treatment of the above-referenced Patient may have been unprofessional as defined in Nevada Revised Statute (NRS) 636.295 and Nevada Administrative Code (NAC) 636.230. The Board indicates that Licensee 1 is to reply on or by the close of business February 12, 2026. (The time to submit the response has been extended to April 30, 2026.)

Below you will find sections which include Licensee 1’s objections and/or requests for clarification, a statement of relevant facts, the allegations and questions set forth in the Board’s letter and Licensee 1’s responses to each of the allegations and questions. In addition, you will find the Curriculum Vitae of Jayanth Sridhar the expert Licensee 1 will rely upon regarding the litigation in this case. Furthermore, you will find the opinions Dr. Sridhar has expressed to date. (The deadline for Initial Expert Witness disclosures is currently August 14, 2026.)

**OBJECTIONS AND/OR REQUESTS FOR CLARIFICATION**

Licensee 1 formally objects to the inclusion of allegations that, upon information and belief, do not relate to his care, treatment and involvement with any patient, including but not limited to The

Patient. Inclusion of any allegations related to other licensed healthcare professionals is entirely improper. Just as a provider of health care is liable only for his or her own conduct in a civil action, Licensee 1 cannot and must not be evaluated and/or disciplined for conduct attributable to another licensed healthcare professional, including but not limited to any alleged failure by another Optometrist (O.D.), Ophthalmologist, any other physician, physician assistant, any other licensed healthcare professional, or any other person during the patient's treatment prior to, concurrent with or subsequent to Licensee 1's involvement in the case. Any inquiry regarding Licensee 1must be limited to his care, treatment and involvement only. Licensee 1, therefore, requests clarification as to the specific allegations made against him individually, if any, so that he is able to properly defend against them in accordance with his due process rights under the Constitution of the State of Nevada and the Constitution of the United States of America. Licensee 1 further reserves the right to supplement or amend this response after receiving this necessary information and clarification. Notwithstanding the foregoing objections, and without waiving and subject to the same, Licensee 1's response is set out below.

## STATEMENT OF FACTS

***Documentation in Medical Records Concerning Care of The Patient***

At the time The Patient, whose date of birth is [REDACTED], presented to Practice Entity 1 on March 27, 2024, he was 84 years old. His chief complaint was Cataract evaluation for blurred vision OS>OD. Gradual changes were noted over the past year. The Patient did wear glasses for distance only but did not bring them. He did not use glasses for reading. He rarely drove but indicated he did not have glare. OU watered a lot but The Patient denied using any eye drops. He rarely saw floaters but no flashes. Over 15 years ago he wore SCL. He reported occasional double vision when he first awakened. He had an eye injury OD at age 40 with a metal foreign body present. He was right handed and right eye dominant. He was on Tamsulosin for prostate enlargement.

The Patient was seen by [OMD 1] who performed an eye examination. Subsequent to the exam, the Impression/Plan included:
1. Combined form of senile cataract OU
Plan: Counseling-Cataracts – refer to education handout for detailed counseling.
After counseling The Patient they decided on the following plan for the right and left eye: Cataract Surgery with IOL.
Plan: Order for Ophthalmic Surgery(comprehensive).
Surgery scheduling order.
Surgeon: OMD 1.
Diagnosis codes: Combined form of senile cataract OU.

Procedure to be performed – OD.
Monofocal IOL Distance OD.
Tonic Distance IOL Candidate OD (+ORA).
Procedure to be performed – OS.
Left eye first then Right eye.
Monofocal IOL. Distance OS.
Tonic Distance IOL Candidate OD (+ORA).
Estimated Time: 15 minutes.
Facility Needed: [Surgery Center 1].

Anesthesia: MAC.

Pathology needed (frozen section): no.

Admission Status: outpatient.
Photos Taken? No.

Provider: [OMD 1].
Priority: normal.

2. Epiretinal Membrane OS

Plan: Counseling – Epiretinal membrane.
I counseled The Patient regarding the following:
Eye Care: Epiretinal membranes do not usually require treatment, unless distorted vision or blurry vision occur. The main treatment consists of vitrectomy surgery with peeling off of the epiretinal membrane.
Expectations: Epiretinal membrane formation is often without symptoms or effect on vision. They occur from aging, previous eye trauma or chronic eye inflammation (such as uveitis). In rare instances, they can progress and have a significant effect on vision.

After counseling The Patient, they decided on the following plan for the left eye: Observation.

3. Irregular Astigmatism OU – Irregular Astigmatism - ? *Forme Fusta Keratoconus given some inferior steepening*
I counseled The Patient regarding the following:
Eye Care: Irregular astigmatism usually prevents someone from seeing clearly through eyeglasses, so hard or gas permeable contact lenses are a reliable way to improve one's vision. Refractive surgery such as LASIK and PRK are usually not successful in patients with irregular astigmatism.

There are no reliable surgical treatments for irregular astigmatism.
Expectations: Irregular astigmatism is a condition comprised of an irregular corneal surface. It can be an inherited condition, or result from corneal scarring or previous ocular surgery. There is also a disease called keratoconus that may present with irregular astigmatism in its early stages.
Contact office if: You experience loss of vision with your glasses or contact lenses, or notice that you need frequent changes in your eyeglass or contact lens prescriptions.

Follow Up
1. Follow Up for Next Visit

Instructions: Schedule surgery.

On May 22, 2024, The Patient returned to Practice Entity 1. He was 1 day post op status following cataract extraction with IOL (with distance) of the left eye. The surgery was performed by [OMD 1] on 5.21.24 at [Surgery Center 1]. The Patient was seen by [OMD 1] at this post op visit.

The Patient reported that since the surgery, he had noticed that objects appeared brighter in the affected eye. He was taking eye medications, ketorolac eye drops (QID), moxifloxacin eye drops (QID) and prednisolone acetate 1% eye drops (QID), as prescribed and had no pain, discharge, or redness.

After examination by [OMD 1], the Impression and Plan included:
1. Postop Cataract OS – 1 day s/p PCIOL OS. Patient doing well.
Associated diagnosis: presence of intraocular lens.

Plan: Post Op Evaluation Cataract.
OS Postop: day 1.
OS Postop: 5/21/2024.
I recommended the following postoperative plan OS:
Continue Regimen: Moxifloxacin, Ketorolac, and Prednisolone QID.

Plan: Set Global Period.
Location: OS.
The following surgery was performed: Cataract Extraction.
The surgery date was 05/21/2024.

Plan: F/U for Next Visit Cataract.
Instructions: RTC as scheduled.

Plan: Counseling – Postop Cataract Surgery.
I counseled The Patient regarding the following:
Eye Care: Most patients recovering from cataract surgery need various eye drops to prevent infection, reduce inflammation, and promote healing. These eye drops need to be used as prescribed, and it is also very important to keep your appointments for postoperative examinations. We also recommend taping a protective plastic eye shield over the eye every night at bedtime, for the first week.
Expectations: Most patients experience a significant improvement in vision by the first postoperative day, but it may take a few weeks for maximum improvement. Occasionally, blurry vision may be present on the first postoperative day for a variety of reasons including having had a hard cataract, corneal swelling, retinal swelling, and complicated surgery. The eye has a tremendous capacity to heal. Your eyeglass prescription usually changes after cataract surgery so your old eyeglasses won't be helpful. A new eyeglass prescription will usually be given after 3-4 weeks of healing.
Contact the office if: Contact the office for any pain, redness, flashing lights, floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.
Postoperative restrictions for cataract surgery patients include no strenuous activity for one week, including no golf, tennis, aerobics, weight lifting, bicycling, or sweating for one week. We also don't allow swimming or eye make up for two weeks after surgery.

The Patient was seen next by [OMD 1] at [Practice Entity 1] on May 29, 2024. The chief complaint was Pre op 2nd eye OD and PO 2nd eye OS (sic). The Patient said that he still did not see a lot of difference after the surgery. His vision was still blurry. He denied ocular pain. He was currently using Pred and Keto BID OS.

The Patient wanted to proceed with surgery on the second eye OD.

OMD 1 examined The Patient and set out the following Impression and Plan:
Impression/Plan:
1. Postop Cataract OS
   Associated diagnosis: Presence of intraocular lens.
Plan: Post Op Evaluation Cataract.
OS Postop: week 1.
OS Postop: 5/21/2024.
I recommended the following postoperative plan OS:
Discontinue Regimen: Decrease Prednisolone to 2x/day as scheduled.
Decrease Ketorolac to 2x/day as scheduled.

Plan: Counseling – Postop Cataract Surgery.
The counseling documented is the same as that documented at the first post op visit on May 22, 2024.

It was added that they discussed that The Patient will need glasses for BCVA due to astigmatism.

2. Combined form of senile cataract OD

Plan: Counseling – Cataracts.
I counseled The Patient regarding the following;
Visually significant: Patient elects to proceed with cataract surgery.

Medical Decision Making – OD.
Will proceed with second eye sx.

Plan: F/U for Next Visit Cataract.
-as scheduled for sx.

On June 11, 2024, The Patient underwent surgery, Phacoemulsification of Cataract and Insertion of Intraocular Lens, right for the cataract in the right eye (OD). The surgery was performed at [Surgery Center 1] by [OMD 1]. Anesthesia time started at 10:50 it was stopped at 11:03 and discharge was at 11:13. Procedure in Detail sets out:

> The patient was brought to operating room. Under intravenous sedation and anesthetic the operative eye was prepped and draped in the usual sterile ophthalmic fashion. A wire lid speculum was placed in the eye. A clear corneal incision was made with 2.7 mm keratome and a secondary stab incision was made to the left. The anterior chamber was filled with viscoelastic and a continuous tear capsulotomy was made.
>
> After hydrodissection, the nucleus was removed with phacoemulsification. The remaining cortex was removed with I&A and capsule polisher. The eye was filled with viscoelastic. The intraocular lens was inserted and centered in the capsular bag.
>
> The viscoelastic was exchanged for balanced salt solution and the anterior chamber was pressurized. No sutures were required. The intraocular lens was verified to be in good position and the wound was verified to be watertight. The speculum was removed from the eye. The patient was awakened and taken to the recovery room in good condition.

(At the bottom left side of the June 11, 2024, Operative Report regarding the right eye (OD) there is a handwritten entry, a circled + mark and BCL. The BCL is not mentioned within the Operative Report.)

Post-op Instructions include Instructions for "Caring For Your Eye." In this section there is a handwritten entry, "*Bandage Contact Lens in place." The Instructions go on with Activities, what is normal and what is unusual.

The Patient presented to [Practice Entity 1] on June 12, 2024. He was 1 DAY s/p PCIOL OD distance. He was seen by Licensee 1. The Patient reported that his vision in OD was still blurry. He was using Ketorolac QID OD/BID OS, Prednisolone QID OD/BID OS and Moxifloxacin QID OD as directed. The Patient indicated that he was told that he has astigmatisms. He stated that he sometimes has the feeling of FB sensation in OS (sic). He does not use AT. He denied any other discomfort at that time.

Examination of OD set out:
Dsc OD 20/60 -2.
PH: 20/25 -2.
IOP OD 17.
OD External normal lid position, nasolacrimal and orbital exam.
OD Lid Margin: quiet and normal.
<u>Slit lamp examination OD</u>:
OD Conjunctiva: white and quiet.
OD Cornea: clear cornea.
OD Anterior Chamber: cell trace.
OD Iris: normal without rubeosis.
OD Lens: PCIOL.
<u>Ophthalmoscopic examination of optic disc OD</u>:
OD: CD ratio 0.45.
OD Optic Disc: UNDILATED.
General Appearance of The Patient is well nourished.
Orientation: alert and oriented x 3.
Mood and affect: no acute distress.
Impression/Plan:
1.Postop Cataract OU
Associated diagnosis: Presence of intraocular lens.
Plan: Post Op Evaluation Cataract.
OD Postop: day 1.
OD Postop: 6/11/24.

I recommended the following postoperative plan OD:
Continue Regimen: Use Moxifloxacin, Ketorolac and Prednisolone as scheduled.
OS Postop: week 3.
OS Postop: 5/21/2024.
I recommended the following postoperative plan OS:
Continue Regimen: Ketorolac and Prednisolone BID as scheduled.
Plan: Counseling – Postop Cataract Surgery.
I counseled The Patient regarding the following:
The counseling documented is the same as what was documented on May 29, 2025, the patient's second postop visit OS and preop visit for OD.

The Patient was seen next on June 18, 2024. He was 1 week postop OD. He was seen by [OMD 2, affiliated with Practice Entity 1]. [OMD 2] set forth the following HPI:
This is an 84 year old male who is being seen for a chief complaint of 1 week PO OD. H/O: OS cataract extraction: 05.21.24 (OMD 1) DISTANCE and OD: 06.11.24 (OMD 1) DISTANCE. Patient reports he noticed minimal VA difference OU. Denies any flashes but reports some floaters OU. Denies any pain, but states some discomfort OS (sic) occasionally (states that feels like he has some contact lens inserted).
Patient states he finished the drops on OS and is using Prednisolone and Ketorolac BID OD.

The eye exam revealed Dsc OD 20/70 -2; PH: 20/30 -2. IOP OD 12.

OD External: normal lid position, nasolacrimal and orbital exam.
OD Lid Margin: quiet and normal.
Slit lamp examination OD:
OD Conjunctiva: white and quiet.
OD Cornea: clear cornea.
OD Anterior Chamber: deep and quiet anterior chamber.
OD Iris: normal iris without rubeosis.
OD Lens: PCIOL in place.
General Appearance of The Patient is well nourished.
Orientation: alert and oriented x 3.
Mood and affect: no acute distress.
Impression/Plan: included:
1.Postop Cataract OU
   Associated diagnosis: Presence of intraocular lens.

Plan: Counseling – Postop Cataract Surgery.
I counseled The Patient regarding the following:

Contact the office if: Contact the office for any pain, redness, flashing lights, floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.

Discussed will need glasses for BCVA due to astigmatism.

Plan: Post Op Evaluation Cataract.
OD Postop: week 1.
OD Postop: 6/11/24.
I recommended the following postoperative plan OD:
Continue Regimen: Prednisolone and Ketorolac BID.
OS Postop: month 1.
OS Postop: 5/21/2024.
I recommended the following postoperative plan OS:

Treatment Regimen: Finished with surgical drops.

Follow Up
1.Follow Up for Next Visit.

Instructions: 4-6 months DFE.

On October 9, 2024, The Patient presented and was seen by [OMD 2]. The HPI sets out that the patient was being seen for a chief complaint of DFE, due to PCIOL OU. The patient’s history included cataract extraction done for OS 05.21.24 (OMD 1) DISTANCE and OD: 06.11.24 (OMD 1) DISTANCE. He said that his vision was still not that great, since he still needed glasses occasionally. The patient reported occasional floaters OU and denied any flashes of light. He also reported occasional tearing and denied any ocular pain or discomfort. He used Refresh every day, but said the frequency depended.

Distance vision on the right was 20/80 -2, PH: 20/50 -2. On the left it was 20/50 +2, PH: 20/25 -2.

Pupils were normal. Each OD and OS Dark was 2.00 mm, size Normal, Round, Regular, Reacted Well and No APD.

IOP was 13 in both OD and OS.

The following was recorded for examination of OD:

OD External: normal lid position, nasolacrimal and orbital exam.
OD Lid Margin: quiet and normal.
Slit lamp examination OD:
OD Conjunctiva: white and quiet.
OD Cornea: clear cornea.
OD Anterior Chamber: deep and quiet anterior chamber.
OD Iris: normal iris without rubeosis.
OD Lens: PCIOL in place, PCO.
**A dilated exam of the optic disc was performed OD [Emphasis added]**
Ophthalmoscopic examination of optic disc OD:
OD: CD ratio 0.45.
OD Optic Disc: flat and normal disc.
A dilated fundus exam was performed OD.
Ophthalmoscopic examination of retina and vessels OD:
OD Vitreous: vitreous clear without hemorrhage, cells or pigment.
OD Vessels: vessels with normal contour, caliber without neovascularization.
OD Macula: ERM, intraretinal fluid.
OD Periphery: periphery normal appearance without retinal tears, breaks, holes or mass.

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

**Tests**

**OCT, Retinal**

A same-day order was placed for this diagnostic test.
Diagnostic Procedure: Retinal Optical Coherence Tomography – OU.

Machine: Cirrus.
Indication: Epiretinal Membrane OU.

Findings OD: epiretinal membrane.
Other Findings OD: macular edema.
OCT Diagnosis OD: epiretinal membrane and macular edema.
Findings OS: epiretinal membrane.

OCT Diagnosis OS: epiretinal membrane.
Reliability: good.
Assessment OD: stable compared to previous study.
Assessment OS: stable compared to previous study.
Impression/Plan included:
1. Epiretinal Membrane OU

Plan: Counseling – Epiretinal membrane.
I counseled The Patient regarding the following:
Eye care: Epiretinal membranes do not usually require treatment, unless distorted vision or blurry vision occur. The main treatment consists of vitrectomy surgery with peeling off of the epiretinal membrane.
Expectations: Epiretinal membrane formation is often without symptoms or effect on vision. They occur from aging, previous eye trauma or surgery, or chronic eye inflammation (such as uveitis). In rare instances, they can progress and have a significant affect on vision.

After counseling The Patient, we decided on the following plan for the left eye. Observation.

2. Clinically Significant Macular Edema OD – *mac edema od with ERM*
*-will start pred/keto qid*
*-refer to [OMD 5 with Practice Entity 2]*
*-will also perform yag cap to improve his view to the retina, od first*
unspecified diabetic type and mild OD.

Plan: Prescription.
prednisolone acetate 1 % eye drops, suspension Ophthalmic (eye).
Location: OD.
Sig: Apply one drop in affected eye 4 times a day.
Quantity: 10 Milliliter Refills: 2 Earliest fill date: October 09, 2024

ketorolac 0.5% eye drops Ophthalmic (eye).
Location: OD.
Sig: Apply one drop in affected 4 times a day.
Quantity: 5 Milliliter Refills: 3 Earliest fill date: October 09, 2024.

Plan: Treatment Regimen.
Start the following treatment(s): Prednisolone QID OD.
Ketorolac QID OD.

3. Irregular Astigmatism OU - ? *Forme Fuste Keratoconus given some inferior steepening*

Plan: Counseling – Irregular Astigmatism.
I counseled the patient regarding the following:
Eye Care: Irregular astigmatism usually prevents someone from seeing clearly through eyeglasses, so hard or gas permeable contact lenses are a reliable way to improve one's vision. Refractive surgery such as LASIK and PRK are usually not successful in patients with irregular astigmatism. There are no reliable surgical treatments for irregular astigmatism.
Expectations: Irregular astigmatism is a condition comprised of an irregular corneal surface. It can be an inherited condition, or result from corneal scarring or previous ocular surgery. There is also a disease called keratoconus that may present with irregular astigmatism in its early stages.
Contact office if: You experience loss of vision with your glasses or contact lenses, or notice that you need frequent changes in your eyeglass or contact lens prescriptions.

4. Posterior Capsular Opacification OU

Plan: Counseling – Posterior Capsular Opacification.
I counseled The Patient regarding the following:
Posterior capsular opacification often requires a YAG laser capsulotomy to remove the opacity and improve the vision.
Posterior capsular opacification is very common after cataract surgery and can occur months to years later. There is no way to prevent its occurrence. It is due to lens epithelial cells that proliferate and coat the clear posterior capsule.

Contact Office if: Posterior capsular opacification progresses and causes a loss of vision that affects your ability to read, drive a car, see street signs, watch TV, or follow the golf ball.

After counseling The Patient, we decided on the following plan for the right eye: YAG laser posterior capsulotomy.

After counseling The Patient, we decided on the following plan for the left eye: YAG laser posterior capsulotomy.

Follow Up
1. Follow Up for Next Visit
Laser OD: YAG Laser Posterior Capsulotomy.
Laser OS: YAG Laser Posterior Capsulotomy.
Instructions: YAG Cap, OD first then OS.

Instructions: refer [OMD 5 affiliated with Practice Entity 2] in 4-6 weeks for macular edema OD.

The Patient's next visit to Practice Entity 1 was on October 15, 2024. He was seen by [OMD 2] for the chief complaint of yag cap OD due to decreased vision.
The plan for Posterior Capsular Opacification OD was YAG Laser Posterior Capsulotomy. The procedure was undertaken by [OMD 2] without complications.
The Patient was instructed to continue using all the same eye drops as before the procedure. He was to call immediately for any pain, lid swelling or tenderness, discharge or loss of vision.

On October 22, 2024, The Patient underwent YAG Laser Posterior Capsulotomy OS by [OMD 2] due to decreased vision. The post procedure instructions were the same as those given for OD.

The Patient was seen by [OMD 2] on October 29, 2024. He was 1 week Yag cap PO OD. He reported that Saturday night after he had eye drops at 11:30 p.m. he noticed vision in OD started to get blurry. When he awakened on Sunday his vision was better. In addition, The Patient reported a foreign body sensation OD since that day. He also complained of pain in the back of OD that came and went. The Patient was taking ketorolac and prednisolone OD three times a day.

Vision in OD was 20/80, PH: 20/30 -2. IOP was 14.

On examination of OD normal lid position, nasolacrimal and orbital exam. Lid Margin was quiet and normal. Slit lamp examination revealed quiet, white conjunctiva, clear cornea, deep and quiet anterior chamber, normal iris without rubeosis, Lens: PCIOL in place, open PC.

There was Clinically Significant Macular Edema OD. *The patient was referred to [OMD 5 affiliated with Practice Entity 2]. He had an appointment upcoming.*

On October 30, 2024, The Patient was seen by Licensee 1. The HPI sets out that he was being seen for evaluation of a chief complaint of pain OD. The Patient said he had been having pain OD since this morning. His eye hurt when he touched it. He went on to say he was unable to see out of OD that day. He noticed change in the visual acuity the night before, and it was getting worse. He had light sensitivity and watering of the eye. He also had headaches on the right which was something new. He saw [OMD 2] the day before. He was told to continue the Prednisolone and Ketoralac QID OD. An appointment with a retina specialist was scheduled on 11/15/24.

Vision in OD was hand motion. IOP was 20.

Slit lamp examination of OD conjunctiva revealed diffuse sub conj heme/injection. The cornea exam noted contact lens present, 2+ DM folds, epi defect 1x3mm. OD Anterior Chamber noted less than 1mm hypopyon.

The following was documented, "Data Reviewed: 3 Ordering of each unique test (Bacteria identified in Eye by Anaerobe+Aerobe culture. Bacteria identified in Eye by Aerobe culture. Fungus identified in Skin Culture)."

A same day order was placed for diagnostic corneal scraping of OD. The indication for the test/procedure was central corneal ulceration.
The Patient read and signed a consent form after risks, benefits and alternative procedures were discussed. Topical anesthesia was obtained with proparacaine drops and a sterile cotton swab was used to scrape the corneal ulcer bed and plate cultures directly on blood agar, chocolate agar and Sabouraud's agar. Cultures were submitted to an outside microbiology lab. The Patient tolerated the procedure and there were no complications. The Patient was to return to the clinic the next day. He was told to call immediately for any pain, lid swelling or tenderness, discharge, or loss of vision.

Impression/Plan included
1. Central Corneal Ulceration OD – *Corneal Infection OD – likely secondary to retained bandage contact lens < 1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
*-Corneal cultures taken of BCL and cornea by [OMD 3 affiliated with Practice Entity 1]. Discussed case with [OMD 1]*
*-Quest pick up conf# 1779259334*

*D/c Prednisolone and Ketorolac*

*Start Moxifloxacin q 1H OD through the night. Discontinue once fortified Abx are ready.*

*Start Fortified Vancomycin 25 mg.ml every hour around the clock (called in to metapharmacy)*
*Start Fortified Tobramycin 15 mg.ml every hour around the clock (called in to metapharmacy)*

*Start Doxycyline 50 gm BID po*
*Start Cyclopentolate TID OD*
*Start Vitamin C 1,000mg (OTC)*

2. Postop YAG Capsulotomy OU
3. Macular Edema OD – *macular edema OU – previously noted by [OMD 2], given*

*corneal compromise, advised to discontinue medication until cornea recovers.*

The Patient was instructed to return the next day at which time he would be seen by [OMD 1].

On October 31, 2024, The Patient returned for cornea follow up. He was there for central corneal ulceration OD. He was seen by [OMD 1]. He stated they found a contact in OD yesterday at SW office. He said that the right eye had not been feeling good for a while, on Sunday the right eye got worse and by Tuesday it was even worse. He saw [OMD 2] on Tuesday and was told that everything was fine. Yesterday, Wednesday, he saw Licensee 1 who consulted with [OMD 3] who found a BCL in OD and told right eye was infected. Cultures were also done of the right eye.
Fortified drops coming tomorrow morning so The Patient had not yet started.
Started Moxifloxacin 1 1H OD through the night and Started Doxycycline 50 mg BID po, also Started Vitamin C 1,000mg.
Did not start Cyclopentolate because the Pharmacy did not have it.

Tomorrow will start Fortified Vancomycin 25 mg/ml and Fortified Tobramycin 15mg/ml every hour around the clock.

The visual acuity in OD remained hand motion. Slit lamp examination of OD revealed:
OD Conjunctiva: diffuse sub conj heme/injection; OD Cornea: dense infiltrate 10mmx6mm nasally; OD Anterior Chamber: 2mm hypopyon with fibrin; OD Iris: normal iris without rubeosis; OD Lens: PCIOL in place, open PC.

The Impression/Plan set out:
1. Central Corneal Ulceration OD – *10/30/2024: Corneal ulcer OD – likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
*-Corneal cultures taken of BCL and cornea by Dr. [OMD 3]. Discussed case with [OMD 1].*
*-Quest pick up cnf# 177925934*
*-D/c Prednisolone and Ketrolac*
*See treatment plan for drops*
*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. Labs still pending and follow up tomorrow.*
*Given worsening will inject sub-conj 50 mcg/ml of Cefazolin – done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

The plan included a treatment regimen. In addition, subconjunctival injection would be undertaken.

The Procedure: Subconjunctival Injection of cefazolin 50 mcg/ml was performed after informed consent was obtained. The Patient tolerated the procedure well and an ophthalmic patch was placed on the eye.

Follow up for the next visit was instructions for The Patient to return the following day at HN office with [OMD 1] urgent.

Medical Decision Making regarding OD included referral to retina specialist with an appointment pending with [OMD 5 affiliated with Practice Entity 2].

The Patient was seen by [OMD 1] next on November 1, 2024, for central corneal ulceration OD. The Patient said that they were doing okay. He denied pain but indicated that when they looked a certain direction they did have slight discomfort. The Patient denied any changes in vision. The visual acuity was not good.

Vision in OD was hand motion.

Slit lamp examination of OD revealed:
OD Conjunctiva: diffuse sub conj heme/injection.
OD Cornea: dense infiltrate 10mmx6mm nasally – much less "goopy" discharge now; ++ associated epi defect over the infiltrate.
OD Anterior Chamber: 2mm hypopyon; Fibrin almost resolved.
OD Iris: normal iris without rubeosis
OD Lens: PCIOL in place, open PC.

The following was added to the Impression/Plan related to the Central Corneal Ulceration OD on 11/1/2024: *Labs: ++ Gram negative bacilli – most likely Pseudomonas A. Final ID pending – can adjust Vanco when final ID back. Stable today from yesterday – hypopyon slightly better and fibrin resolving. Recommended another inject sub-conj 50 mg.ml of Cefazolin – done today. Slit lamp photos taken today.*

Counseling regarding the corneal ulcer included the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea.
Expectations: Corneal ulcers are serious infections of the eye that extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.

The Patient was informed that because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at local pharmacy.
Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Subconjunctival injection of cefazoline 50 mcg/ml was done.

The Patient was instructed to return to the clinic on Monday at 4 pm for follow up with [OMD 4, affiliated with Practice Entity 1].

The patient did return on November 4, 2024. He reported there were no changes in the visual acuity. He still had occasional pain, OD when moving eyes in certain direction. He was compliant with drops, OU and Doxycycline. Hand motion vision in OD continued.

The patient was seen by [OMD 4 at Practice Entity 1]. The following was noted on examination. OD External: NV on lid margin. OD Lid Margin: debris on lid.

The only change on the Slit lamp examination OD was OD Conjunctiva: 3-4+ Injection.

The following was added to Impression/Plan;

1. Central Corneal Ulceration OD- *11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/20. Slit lamp photos taken today. Plan for f/u with [OMD 4] on Wed 11/6 and f/u PMO on Friday 11/8*

On November 6, 2024, The Patient was seen for follow up by [OMD 4 at Practice Entity 1]. The chief complaint was Central Corneal Ulceration OD and Macular Edema OD, s/p PCIOL, YAG CAP,OU. The patient said he had not noticed a change in VA OU. He reported having some irritation and pain and that he had been noticing some tearing.

The only change on the Slit lamp examination OD was related to OD Cornea which noted less dense infiltrate 10mmx6mm nasally – much less discharge now; ++ associated epi defect over the infiltrate (see EMA photo tab).

Impression/Plan related to 1. Central Corneal Ulceration OD it was noted *11/06/24: Slight improvement in hyphema, less infiltrate on today's exam. Slit lamp photos taken, Cont. drop regimen.*

The Patient presented again on November 8, 2024. He was seen by [OMD 3, affiliated with Practice

Entity 1]. He reported that everything was about the same. He stated that he has pain OD of 3 on the scale of 1-10. He complained of discharge and tearing all the time which was removed with a "splash of some water." He felt relief when he closed his eyes. He stated that OS was fine.

Slit lamp examination OD showed some improvement. OD Conjunctiva: 2+ injection; OD Cornea: less dense infiltrate 6mmx4.5mm nasally – much less discharge now; ++ associate epi defect over the infiltrate, diffuse PEE's; OD Anterior Chamber: 2mm hypopyon inferonasal.

Impression/Plan concerning 1. Central Corneal Ulceration OD – added *11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont drop regimen. Will start on Brimonidine BID OD – erx'd (Alphagen sample given in office: and Dorzolamide BID OD.*

The Patient was instructed to follow up with [OMD 4 at Practice Entity 1] on 11.11.24.

[OMD 4 at Practice Entity 1] saw The Patient when he returned on November 11, 2024. The Patient stated there were no changes in OU VA, some pain with movement of the right eye. The Patient said he was using all of the prescribed medication except dorzolamide. It was not available at CVS. His daughter was aware that she would need to use another pharmacy.

The following examination was documented: OD External: NV on lid margin slight ectropion LL.

Slit lamp examination of OD: OD conjunctiva: 3+ injection; OD Cornea: less dense infiltrate 6mmx4.5mm nasally – much less discharge now; ++ associated epi defect over the infiltrate, diffuse PEE's; OD Anterior Chamber: 2mm hypopyon inferonasal; OD Iris: normal iris without rubeosis; OD Lens: PCIOL in place, open PC.

The following was added to Impression/Plan related to 1. Central Corneal Ulceration OD- *11.11.24: slight improvement on today's exam. Patient is to continue all drops as directed and return on Friday for follow up*.

The Patient had an appointment for Retina and advised that best to cancel for now until OD improves – OD Instructions: RTC Friday at Summerlin office, make appointment with [OMD 1] when patient returns.

The Patient returned on November 15, 2024. He was seen by [OMD 3 at Practice Entity 1]. Patient reported that OD felt a little better since his last visit. He reported no pain or discomfort and was using all medications as instructed.

The slit lamp examination included that OD Cornea had less dense infiltrate 7mmx4mm nasally ++ still associated epi defect over the infiltrate, 3+ PEE's and OD Anterior Chamber: 2mm hypopyon inferonasal ➔ resolved.

The following was added to the Impression/Plan regarding Central Corneal Ulceration OD – *11/15/24: Slight continuous improvement. Spoke with [OMD 4 affiliated with Practice Entity 1] and [OMD 2 affiliated with Practice Entity 1] and adjusted drops for patient. Will follow up on Monday with [OMD 1].*

When The Patient returned on November 18, 2024, he saw [OMD 1]. He indicated that he had no pain but the vision was not good. He was using Moxifloxacin qid, Vancomycin qid, Tobramycin q2h, Pred 1% BID, Combigan BID, Dorzolamide BID OD and doxycycline 50 mg BID PO. In addition, he was using Refresh 5-6 x OD and a few OS.

Vision in OD remained hand motion.

*11/18/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen* was added to 1. Central Corneal Ulceration OD. In addition, Pseudophakia OU Impression/Plan.

The Patient was next seen on November 22, 2024. He was seen by [OMD 1]. He denied pain and stated everything was the same as the last visit.

The only change on the Slit lamp examination related to OD Anterior Chamber: there was no hypopyon.

The note regarding Central Cornel Ulceration OD was the same as that entered on 11/18/24. Pt to be seen next WED was added.

On November 27, 2024, The Patient was seen by [OMD 1]. He was frustrated that it was difficult to do things. He was using OTC readers. He was using Dorzolamide BID OD, Moxifloxacin QID OD, Prednisolone TID OD, Tobramycin 6x/day OD WA, Doxycycline 50mg QD, Vitamin C 1,000mg, and AT's 4x/day OU.

On Slit lamp examination the only change was related to OD Cornea which set out, less dense infiltrate 7mmx4mm nasally – ++ still associated 1x2 mm very linear epi defect over the infiltrate (healing); 3+ PEE's.

The following was added to the Impression/Plan regarding 1. Central Corneal Ulceration OD, *11/27/24: Epi defect smaller and healing. IOP stable OD.*

The Patient was instructed to follow up with [OMD 1] in 1 week on Wednesday at [Practice Entity 1 location].

The Patient did return for follow up on December 4, 2024. He was seen by [OMD 1]. He said that it seemed like his vision in OD was slightly improved. He denied pain.

Vision in OD was documented CF@1ft. IOP was 13 in OD. Slit lamp examination of OD Cornea: set out less dense infiltrate 7 mmx4mm nasally -- ++ Still associated 1 x 0.5 mm very linear epi defect over the infiltrate (healing); 3 + PEE's.

The following was noted regarding Impression/Plan for 1. Central Corneal Ulceration OD – *12/04/24: Epi defect getting smaller and healing. IOP stable OD.*

It was noted that The Patient was followed by retina specialist.

He was instructed to see [OMD 1] next Friday 12/13 at [Practice Entity 1 location].

On December 13, 2024, The Patient presented for follow up and was seen by [OMD 1]. He stated that there was some visual improvement OD compared to his last appointment. He denied ocular pain but reported some discomfort due to decreased vision OD. He denied other visual disturbances.

Distance vision in OD was again CF@1ft, PH:NI IOP in OD was 12.

Slit lamp examination of OD included OD Cornea: less dense infiltrate 7mmx4mm nasally ➔ becoming scar now; NO epi defect; 3+ PEE's.

*12/13/23: NO epi defect, infiltrate becoming scar now, IOP stable OD* was added to Impression/Plan related to 1. Central Corneal Ulceration OD.

The Patient was instructed to return for follow up on 12/26 @ 12pm at [Practice Entity 1 location] with [OMD 1].

The Patient was seen by [OMD 1] on December 26, 2024. Distance vision OD was CF@2ft. PH: N1 and IOP 16.

Findings noted on Slit lamp examination OD included, OD Conjunctiva: very tr injection; OD Cornea: diffuse scarring (prior 4x 7 mm infiltrate) NO epi defect; 3+ PEE's; and OD Anterior Chamber: deep and quiet.

Impression/Plan regarding 1. Central Corneal Ulceration OD set out *12/26/24: Improving; resolved infiltrate with scar now; inflammation much improved.*

The Patient was seen by [OMD 1] for 2 weeks follow up on January 9, 2025. He reported that maybe there was some improvement in OD VA. He was using ATs OU twice a day. In addition, he was using Pred OD three times a day, Tobramycin OD twice a day, Doxy 50 mg by mouth daily and Vit C 1000 mg by mouth each day.

On examination The Patient's vision in OD was CF@2ft PH: 20/400. There were no changes on the slit lamp exam of OD.

The note related to the Impression/Plan 1. Central Corneal Ulceration OD for *01/09/25* states *Improved, resolved infiltrate with scar now; inflammation much improved, IOP stable.*

The Patient was instructed to follow with [OMD 1] at [Practice Entity 1 location] in 2-3 weeks.

On January 24, 2025, The Patient was seen for follow up with [OMD 1]. Distance vision OD was CF@4ft. IOP OD was 12. OD external exam noted NV on lid margin slight ectropion LL.

The note entered for *01/24/25:*sets out *Over stable. No infiltrates. Will continue current regimen. Will see if scar reduces or fades over next few weeks, will consider corneal transplant vs Hard Cls in the future.*

The Patient would follow up in 1 month with [OMD 1].

The Patient presented for follow up on February 14, 2025. He reported that overall vision was still blurred but stable distance.

His vision OD was noted to be 20/400 PH: 20/200. IOP OD was 12.

External exam of OD noted dermatochalasis NV on lid margin slight ectropion LL. No changes were documented on the slit lamp examination OD.

Impression/Plan for Central Corneal Ulceration OD was *2/14/25: Stable exam. No infiltrates. Continue adjusted regimen.*

The Patient was to follow up in 1 month with OMD 1 and TOPO and Anterior Segment OCT, OD.

March 14, 2025, The Patient presented for follow up with [OMD 1]. Vision in OD was CF@2ft PH: 20/80 -2. IOP was 13.

The note under Impression/Plan on *03/14/25* states *Stable, no infiltrates. Diffuse scarring slightly fading. Patient hesitant on PKP OD, discussed can be fitted with Scleral lens or RGP, even if unable to tolerate can see what BCVA is OD. Pt has second opinion with [OMD 6 affiliated with Practice Entity 3].*

The Patient was to follow up with [OMD 1] in 6 weeks.

The March 14, 2025, Visit Note is the last note contained within the records that were provided.

## RESPONSE TO ALLEGATIONS

**The Office of the Nevada State Board of Optometry (Board) has been apprised of allegations that your care and treatment of the Patient may have been unprofessional as defined in Nevada Revised Statute (NRS) 636.295 and Nevada Administrative Code (NAC) 636.230.**

Licensee 1 objects to these allegations as he has no firsthand knowledge of the Nevada State Board of Optometry being apprised that his care and treatment of the Patient or any other patient may have been unprofessional as defined in Nevada Revised Statute (NRS) 636.295 and Nevada Administrative Code (NAC) 636.230.

In addition, Licensee 1 objects to the allegations as they are overly broad and vague and ambiguous. He further objects as this is merely a statement without specific allegations and therefore no response is possible and/or required.

Moreover, Licensee 1 objects to this statement as it does not put him on notice regarding how his care and treatment may have been unprofessional as defined in NRS 636.295 and NAC 636.230, and may have violated any standard of care, standard of practice, statute or any other authority. He is therefore deprived of his due process rights under the Constitution of the State of Nevada and the Constitution of the United States of America.

Licensee 1 responds that all of the care and treatment he provided to The Patient was within the standard of care and was in no way unprofessional.

**The complaint alleges on or about June 11, 2024, ophthalmologist OMD 1 performed cataracts surgery upon the patient's right eye. OMD 1's operative report documented placement of a bandage contact lens (BCL). On or about June 12, 2024, the patient presented**

**to you for his first post-operative follow-up. You allegedly breached the standard of care by:**

**Failing to review Plaintiff's operative report and surgical records before providing care;**

Licensee 1 objects to these allegations as they misstate and mischaracterize the facts. In addition, he objects to the allegations as they are overly board and vague and ambiguous.

Furthermore, Licensee 1 objects to the allegation to the extent that they relate to and involve care and treatment provided by other healthcare and medical providers. As set out above, inclusion of allegations related to other licenses medical professionals, any other medical care providers, or any other persons is entirely improper.

Notwithstanding, without waiving and subject to objections, Licensee 1 responds:
Licensee 1 saw The Patient on June 12, 2024. This was Licensee 1's first encounter with The Patient. The Patient was 1 DAY status post posterior chamber intraocular lens (PCIOL).

The Patient's surgery which was performed by OMD 1 was done at [Surgery Center 1] on June 11, 2024, at or around 10:50 AM.

When Licensee 1 saw The Patient at the first postoperative visit on June 12, 2024, the Operative Report had not been placed in the portal and was not available to Licensee 1. OMD 1 had not informed Licensee 1 that a BCL was placed. Generally unless there is reason for concern a full examination of the eye is not performed when a patient is 1 day PO. In this case there was no reason for Licensee 1 to be concerned. Licensee 1 did do a slit lamp examination of OD and noted that the conjunctive was white and quiet, the cornea was clear, there was cell trace in the anterior chamber, the iris was normal and there was a PCIOL OD.

The expert witness who is anticipated to be disclosed in the associated litigation, has indicated that in a perfect world Licensee 1 would have noted the presence of bandage lens. However, Licensee 1 had not been informed that a BCL was used and there was no reason for him to assume that it would be present. In fact, had Licensee 1 known and/or identified that there was a BCL present it would not have changed his management, treatment and care. If BCL, which are continuous extended wear are used, it is recommended that they be worn for 3 to 7 days after cataract surgeries and PRK.

The Patient's postoperative and other care was provided thereafter by OMD 2 [affiliated with Practice Entity 1]. OMD 2 saw the patient on June 18, 2024. At that visit, The Patient was instructed to follow up in 4-6 months for DFE (Dilated Fundus Exam).

Thereafter, The Patient presented to Practice Entity 1 on October 9, October 15, October 22, and October 29, 2024. OMD 2 saw The Patient at each of these visits.

At the October 15, 2024, visit OMD 2 performed a YAG Laser Posterior Capsulotomy OD due to decreased vision. OMD 2 undertook the same procedure OS on October 22, 2024.

OMD 2 saw The Patient on October 29, 2024, at which time he was 1 week post Yag cap OD and 7 days post procedure OS. He reported that after his eye drops at 11:30 p.m. on Saturday night October 26th, he noticed the vision in OD began to get blurry. He went on to say that when he awakened on Sunday morning vision was better. The Patient stated that he was having a foreign body (FB) sensation OD since then. He had previously informed OMD 2 on June 18, 2024, when he was 1 week postoperative OD, that he felt like he had some contact lens inserted.

Licensee 1 saw The Patient on October 30, 2024, which was the 2nd time he saw The Patient, the first encounter having been on June 12, 2024, when he was 1 day postop. As set out above and in the medical records, The Patient had pain OD which had been present since the morning. He stated that it hurt when he touched it. In addition, The Patient said that he was unable to see out of OD at that time. He noticed a change in the visual acuity the night before. The Patient, additionally, indicated that he had issues with light sensitivity and watering OD. Furthermore, he complained of headaches on the right side which was something new.

Vision in OD was hand motion.

Findings on the slit lamp examination OD performed by Licensee 1 included OD Conjunctiva – diffuse sub conj heme/injection; OD Cornea – <u>contact lens present 2+ DM folds, epi defect 1x3 mm</u>; OD Anterior Chamber – less than 1mm hypopyon and OD Lens – PCIOL in place, open PC.

Licensee 1 discussed the finding of the BCL and the issues the patient was having with [OMD 3 at Practice Entity 1] who discussed the case with OMD 1. [OMD 3] performed Diagnostic Corneal Scraping and cultures were were sent to an outside lab. The Patient tolerated the procedure well. He was instructed to return to Practice Entity 1 the next day. In addition, he was told to call immediately for any pain, lid swelling or tenderness, discharge, or loss of vision.

The Patient did return on October 31, 2024. He was seen by OMD 1.

When Licensee 1 first saw The Patient on June 12, 2024, he had no reason to presume that a bandage contact lens had been placed. OMD 1 had not advised him of any complications of the cataract surgery she undertook on OD the day before. In addition, OMD 1 did not tell Licensee 1 that she had placed a bandage contact lens.

In this case, even had Licensee 1 known at the time of the first postoperative visit the day after the cataract surgery OD was done that a bandage contact lens had been placed at the time of the surgery the day before, if would not have changed the management and/or treatment of the patient. Leaving the bandage contact lens in place at that point would have been fine and within the standard of care given the antibiotic coverage.

Pain, dry eye discomfort, and visual rehabilitation are the most common postoperative complications of eye surgeries. Complications such as corneal haze and delayed visual rehabilitation can be prevented with adequate postoperative measures. As the corneal surface will regenerate in 2 to 4 days, in order to prevent the complications, bandage contact lenses (BCLS) are recommended as continuous extended wear for 3 to 7 days after cataract and PRK surgeries.

Bandage contact lenses can be kept in for a few weeks, depending on the eye condition. Most recommend the bandage contact lenses not be worn longer than 21 days.

As to the allegations that the Operative Report for the June 11, 2024, Phacoemulsification of Cataract OD, Licensee 1 has had an opportunity to review the Operative Report and states that the Procedure Details do not include that a bandage contact lens (BCL) had been placed. At the bottom left hand corner of the Operative Report there is a + sign that is circled and BCL written thereafter.

**Failing to perform adequate examinations that would have revealed the retained contact lens;**

Licensee 1 objects to this allegations is it is inaccurate as to an adequate examination.

Subject to, notwithstanding and without waiving objections, Licensee 1 responds that when he saw The Patient on June 12, 2024, the first day postop for the OD cataract surgery, the examination he performed was appropriate and within the standard of care. As noted above, the Operative Report had not been placed in the portal and was not available to him. In addition, OMD 1 the doctor who performed that surgery had not advised him of any complications and/or that [OMD 1] had placed a BCL.

If used, it is recommended that bandage contact lenses which are continuous extended wear remain for at least 3 to 7 days after cataract surgery. The BCL may remain for an a time beyond the 3 to 7 days without issues.

**Failing to recognize, document or address the BCL presence during multiple examinations over 4+ months;**

Licensee 1 objects to these allegations as they misstate facts and are untrue.

Notwithstanding, without waiving and subject to objections, Licensee 1 did not see and/or examine The Patient on multiple occasions over 4 + months. As set out herein and in the medical records, Licensee 1 saw the patient on June 12, 2024, when he was 1 day PO OD. Thereafter, Licensee 1 did not see the patient again until October 30, 2024. At that time, Licensee 1 noted on the slit lamp exam of the cornea that a contact lens was present. He discussed this finding with [OMD 3 at Practice Entity 1] who discussed the case with OMD 1.

[OMD 3] addressed the issue by performing corneal scraping and sending the scrapings to an outside lab for examination.

**Failing to correlate Plaintiff’s ongoing complaints of discomfort and vision issues with potential retained device;**

Licensee 1 objects to these allegations as they misstate facts and are untrue. In addition, Licensee 1 objects to the allegations as they do not apply to him.

Subject to, without waiving and notwithstanding the objections, Licensee 1 saw The Patient only twice during the course of his care and treatment at Practice Entity 1. As set out above, he saw The Patient the first day PO OD, June 12, 2024. Thereafter, The Patient’s post operative care was provided by OMD 2 who saw The Patient on June 18, October 9, October 15, October 22, and October 29, 2024.

Thereafter, Licensee 1 saw The Patient on October 30, 2024. At that time, Licensee 1 identified the presence of a contact lens on OD cornea.

**Failing to communicate with the operating surgeon regarding post-operative course and concerns;**

Licensee 1 objects to these allegations as they misstate facts and are untrue. In addition, Licensee 1 objects to the allegations as they do not apply to him.

**Continuing to perform procedures (YAG laser) without ensuring complete knowledge of eye condition; and**

Licensee 1 objects to these allegations as they misstate facts and are untrue. In addition, Licensee 1 objects to the allegations as they do not apply to him.

/ / /

**Failing to maintain appropriate post-operative communication protocols.**

Licensee 1 objects to these allegations as they misstate facts and are untrue. In addition, Licensee 1 objects to the allegations as they do not apply to him.

Again, Licensee 1 saw The Patient June 12, 2024, the first day PO OD. He did not see The Patient again until October 30, 2024. At that time, Licensee 1 identified a contact lens on OD cornea. He appropriately discussed the issues with [OMD 3] who in turned discussed the case with OMD 1 the surgeon who performed the cataract surgery OD on June 11th.

**If not already included in your response to the above-listed allegations/alleged failures, ensure your response includes an explanation as to the following:**

1) **Did you see the BCL? If not, why not?**

Licensee responded to this question in his response to the allegation of **Failing to review Plaintiff's operative report and surgical records before providing care.**

The Operative report related to the June 11, 2024, surgery performed at [Surgery Center 1] had not been placed in the portal and was not available for Licensee to review at the 1 day post op visit. Licensee 1 was not informed by OMD 1 that a BCL had been placed and he had no reason to suspect there was a BCL. The patient was doing well, was apparently unaware that a BCL had been placed and Licensee 1 did not see the BCL.

2) **Did you document the BCL? If not, why not?**

Licensee 1 documented the presence of the BCL when he saw The Patient on October 30, 2024, which was the second time that he saw The Patient.

3) **Did you remove the BCL? If no, why not?**

The BCL was removed on October 30, 2024, when it was identified by Licensee 1.

4) **Did you receive instructions from OMD 1 about how to manage the BCL and did you follow such instructions? If you did not receive any such instructions about the BCL:**

See above responses.

/ / /

**a) How did you decide to not remove the BCL?; b) did you manage the patient any differently compared to a post-op patient without a BCL? If so, how so?**

See responses above. Licensee 1 did not see the BCL during the June 12, 2024, visit. Even if he had he would not likely have removed the BCL as it was PO day 1 OD. The recommendation is the BCLs be worn for 3 to 7 days. They can be worn for longer periods of time.

**5) How did you decide on exactly a 6-day follow-up with this patient? Is that your custom and practice for post-operative patients similar to this patient? Or was that based upon your knowledge of the BCL?**

Licensee 1 objects to this question as it is vague and ambiguous.

Subject to, without waiving and notwithstanding the objections, when Licensee 1 saw the patient on June 12, 2024, The Patient’s follow had been scheduled. The Patient was told to follow up as scheduled.

**6) Did you provide any instructions to or discuss with OMD 2 your plans, be it a recommendation to remove the BCL versus continue with OMD 1’s plans? If not, why not?**

See medical records and above responses.

**7) Did you review OMD 1’s operative report by the time you rendered care to the patient on or about June 12, 2024? If not, why not?**

See above response. When Licensee 1 saw The Patient on June 12, 2024, the operative report from the surgery the day before at [Surgery Center 1] had not been placed in the portal. As such the Operative Report was not available.

**8) Were you notified of any surgical complications as to why the BCL was placed and that you were supposed to monitor the BCL? If not, did you inquire of OMD 1 about any surgical complications or usage of the BCL?**

As noted herein, surgeon OMD 1 did not communicate with Licensee 1 regarding the June 11, 2024, surgery.

**9) Did you review the post-operative medication schedule, more specifically the use of antibiotic eye drops (if applicable)? If not, why not?**

The post-operative medication schedule was the typical schedule which is used regardless of

whether a BCL is used.

As set out above, Licensee 1 saw The Patient on June 11, 2024, at which time he was 1 day post op cataract surgery OD. He did not see The Patient again until October 24, 2024. The Patient's post operative medical schedule including antibiotic eye drops was managed by OMD 2 who provided care as set out in the medical records and above.

10) **Was your conduct unprofessional as defined by as defined in Nevada Revised Statute NRS 636.295 and Nevada Administrative Code (NAC) 636.230? If not? Why not?**

Licensee 1 states that his conduct was not unprofessional pursuant to any definition. All of the care and treatment he provided at each of the two visits when he saw The Patient was completely within the standard of care.

**If any particular allegations referenced above did occur, and depending on the facts and circumstances, the you may have violated the law, specifically including but not limited to NRS 636.295(8) (unprofessional conduct in the practice of optometry).**

First and foremost, Licensee 1 denies any and all allegations, express or implied, that he may have violated any provisions of Chapter 636 of the Nevada Revised Statutes and the Nevada Administrative Code (Chapter 636) during his involvement with the alleged issues related to The Patient or any other patient. In addition, Licensee 1 denies any and all allegations, express or implied, that he may have violated any governing statutes, codes, any standards of practice and/or any standards of care.

**NRS 636.295 Grounds.** The following acts, conduct, omissions, or mental or physical conditions, or any of them, committed, engaged in, omitted, or begin suffered by a licensee, constitute sufficient cause for disciplinary action:

8. Perpetration of unethical or unprofessional conduct in the practice of optometry.

**NAC 636.230 Compliance with provisions of NAC and NRS relating to optometry.** (NRS 636.125, 636.295) For the purposes of NRS 636.295, the Board will consider the failure of a licensee to comply with any provision of NRS or NAC which relates to the practice of optometry to constitute unprofessional conduct.

Licensee 1 specifically denies that his conduct may be considered unprofessional conduct pursuant to NRS 636.295 and NAC 636.230. The conduct enumerated in the statute as unprofessional

conduct is inapplicable to the subject allegations. None of the express examples of unprofessional conduct delineated in the statute apply to the allegations in this matter.

Licensee 1 denies that any of his behavior was unprofessional. He acted professionally at all times in every aspect of the care, treatment and his involvement related to this matter, including his involvement with the Patient. Thus, Licensee did not commit unprofessional conduct as set out in NRS 636.295 and NAC 636.230, or any other manner, and the Board should close this matter completely. However, if the Board should determine that additional proceedings are warranted, Licensee 1 respectfully asks that the Board clarify what specific conduct solely attributable to him could be deemed to be unprofessional conduct pursuant to NRS 636.295 and NAC 636.230. Licensee 1 reserves the right to supplement this response after he receives such clarification.

As set out herein, all of the functions Licensee 1 performed relative to involvement in the instant matter were consistent with established and customary standards, Therefore, Licensee 1 requests that this matter be closed. If the Board should determine that additional proceedings are warranted, Licensee 1 requests clarification as to the specific function(s) he failed to perform in a manner consistent with established and customary standards, as well as clarification related to what those established and customary standards may be. Licensee 1 reserves the right to supplement this response upon receiving clarification.

## **CONCLUSION**

Licensee 1 met the standard of care at all times while providing services including but not limited to care and treatment and his involvement in the matters related to The Patient. He denies any and all allegations, express or implied, that he violated any provision or section of NRS or NAC Chapter 636, any other provisions of NRS or NAC, or any other authority, guideline or standard.

Licensee 1 did not breach the standard of care or the standards of practice in any manner when providing care to The Patient or in any other manner. Licensee 1, therefore, respectfully requests that the Board close its investigation and take no further action.

Licensee 1 has worked to fully respond to all of the allegations set out in the Board's letter. He hopes that his input and response will be helpful to the Board in its efforts to investigate this matter.

Licensee 1 appreciates the Board's attention to this matter. He looks forward to hearing that the investigation has been completely resolved.

If you have any questions following your review of this correspondence and supporting documentation, or if there is additional information you may require, please contact counsel to

advise of the same. Counsel will work to get answers to any questions and to obtain infonnation that may be requested.

Respectfully submitted,

Marie Ellerton, Esq.
HALL PRANGLE, LLC

*[Licensee 1 signature]*
[Licensee 1]

SME
Enclosures as noted

Jayanth Sridhar
(786) 368-5016
jsridhar119@gmail.com

## EDUCATION

**University of Miami Miller School of Medicine (UMMSM),** Miami, FL May 2010
Doctorate of Medicine

**Honors Program in Medicine**
This prestigious program enables students to combine their third and fourth years of undergraduate studies and their first year of medical school, completing both the BS and MD degrees in 6 years.

**University of Miami, Coral Gables, FL** May 2008
College of Arts and Sciences: Major: Biology Minor: Chemistry
Bachelor of Science, GPA 4.0

## RESIDENCY EDUCATION

**Jackson Health System/Bascom Palmer Eye Institute,** Miami, FL July 2011-June 2014
Department of Ophthalmology, PGY 2-4

**Mount Sinai Medical Center (MSMC),** Miami, FL June 2010-June 2011
Department of Internal Medicine, PGY-1

## POST-RESIDENCY EDUCATION

**Wills Eye Hospital Retina Service,** Philadelphia, PA July 2014-July 2016
Vitreoretinal Surgical Fellow

## PROFESSIONAL EXPERIENCE

**Bascom Palmer Eye Institute, University of Miami,** Miami, FL Sept 2016-present
Voluntary Assistant Professor of Clinical Ophthalmology July 2023-present
Associate Professor of Clinical Ophthalmology, Vitreoretinal Surgeon June 2020-June 2023
Assistant Professor of Clinical Ophthalmology, Vitreoretinal Surgeon Sept 2016-June 2020

**Olive View Medical Center/Los Angeles County,** Sylmar, CA July 2023-present
Chief of Ophthalmology, Vitreoretinal Surgeon

**Jules Stein Eye Institute, University of California, Los Angeles** July 2023-present
Associate Health Sciences Professor of Ophthalmology

## CERTIFICATIONS

**American Board of Ophthalmology** Oct 2015-present

## LICENSURE

**Florida Board of Medicine, Medical Board of California**

## HONORS/AWARDS

**Post-Fellowship**

- 2024 Department of Ophthalmology Teaching Award, Jules Stein Eye Institute
- 2023 American Society of Retinal Specialists Presidential Honor Award
- 2023 Real World Ophthalmology “Inspiring Academic Mentor” Award
- 2023 Inductee Macula Society
- 2022 “Forty Under 40 Ophthalmologists”, *Review of Ophthalmology*
- 2022 “One to Watch in Retina”, *Retina Today*
- 2021 “Professor of the Year”, Bascom Palmer Eye Institute
- 2020 American Academy of Ophthalmology Secretariat Award
- 2020 American Academy of Ophthalmology Achievement Award
- 2020 Inductee Retina Society

- 2019 American Society of Retinal Specialists Senior Honor Award
- 2018 Selected for Allergan FIRST (Fostering Innovative Retina Stars of Tomorrow) program

**Fellowship**

- William Tasman MD Outstanding Fellow Teaching Award, awarded by the graduating residency class at Wills Eye Hospital
- Wills Eye Foundation Innovation Grant 2015-2016: The utility of a structured video indirect ophthalmoscope guided educational program in improving resident ophthalmologist comfort and ability with indirect ophthalmoscopy and scleral depression examination maneuvers. PI: James P Dunn

**Residency**

- 2010-2011 MSMC "Intern of the Year", Department of Internal Medicine

**Medical School**:

- Graduated 1st out of class of 159 students
- 2010 J. Milton Award in Obstetrics-Gynecology
- 2010 Excellence in Physiology Award
- Junior Alpha Omega Alpha, inducted Spring 2009
- 2007-2009 Thomas Brown McClelland Trust Medical Scholarship Recipient

**Undergraduate:**

- Phi Beta Kappa, inducted Spring 2006
- Graduated 1st out of class of 636 students in University of Miami College of Arts and Sciences
- 2004-2006 Bowman Foster Ashe Full Tuition Scholarship Recipient

**PEER-REVIEWED PUBLICATIONS (Reverse Chronological Order, H index 31 Google Scholar as of 11/7/25)**

Barthelemy N, **Sridhar J,** Sengillo JD. Gene Therapy for Wet Age-Related Macular Degeneration. Bioengineering (Basel): 2025 Oct;12:1072.

Vakharia P, **Sridhar J**. Controversies in ophthalmology – challenges and crossroads in 2025. Curr Opin Ophthalmol. 2025 Sep;36:343-344.

Avadzadeh S…International Retina Biosimilar Study Group (Inter BIOS Group). Aflibercept 2mg biosimilar (Tyalia)-real-world experience from IRAN (ATRIA study). Eye (Lond). 2025 Aug;39:2159-2163.

Zaidi H, **Sridhar J**. Optical Coherence Tomography in Retinal Detachment: Prognostic Biomarkers, Surgical Planning, and Postoperative Monitoring. Diagnostics (Basel). 2025 Mar;15:871.

Chawla K, Tailor PD, **Sridhar J**. Evaluating the necessity of topical and subconjunctival antibiotic prophylaxis in ocular surgery. Curr Opin Ophthalmol. 2025 Mar [Online ahead of print].

**Sridhar J**, Kuriyan AE. The ever-changing world of medical and surgical retina: a 2025 snapshot. Curr Opin Ophthalmol. 2025 May;36:159-160.

Gunawardene AN, Suraneni S, Rohowetz LJ, **Sridhar J**. Characteristics and Medical Accuracy of Online Discussions of Retinal Conditions on a Social Media Platform. J Vitreoretin Dis. 2025 Feb [Online ahead of print]

Kalavar M, **Sridhar J**. Clinical trials and real-world studies examining faricimab and high-dose aflibercept for wet age-related macular degeneration and diabetic macular edema. Curr Opin Ophthalmol. 2025 May;36:189-198.

Qaseem Y, Ben Margines J, Song W, Au A, Gupta OP, **Sridhar J**. Scleral fixation of an Intraocular Lens with Gore-Tex Suture from a Temporal Approach. Ophthalmic Surg Lasers Imaging Retina. 2025 Mar;56:136-138.

**Plan: Counseling - Postop Cataract Surgery.**
I counseled the patient regarding the following:
Eye Care: Most patients recovering from cataract surgery need various eye drops to prevent infection, reduce inflammation, and promote healing. These eye drops need to be used as prescribed, and it is also very important to keep your appointments for postoperative examinations. We also recommend taping a protective plastic eye shield over the eye every night at bedtime, for the first week.
Expectations: Most patients experience a significant improvement in vision by the first postoperative day, but it may take a few weeks for maximum improvement. Occasionally, blurry vision may be present on the first postoperative day for a variety of reasons including having had a hard cataract, corneal swelling, retinal swelling, and complicated surgery. The eye has a tremendous capacity to heal. Your eyeglass prescription usually changes after cataract surgery so your old eyeglasses won't be helpful. A new eyeglass prescription will usually be given after 3-4 weeks of healing.
Contact the office if: Contact the office for any pain, redness, flashing lights, floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.
Postoperative restrictions for cataract surgery patients include no strenuous activity for one week, including no golf, tennis, aerobics, weight lifting, bicycling, or sweating for one week. We also don't allow swimming or eye make up for two weeks after surgery.

## Staff:

MD (Primary Provider) (Bill Under)

(scribe)

I, am scribing for, and in the presence of , MD.

Electronically Signed By: , 05/22/2024 09:18 AM PDT

I, , MD, personally performed the services described in the documentation as scribed by in my presence, and confirm it is both accurate and complete.

Electronically Signed By: , MD, 05/22/2024 09:18 AM PDT

**Plan: Post Op Evaluation Cataract.**
OS Postop: week 1
OS Postop: 5/21/2024
I recommended the following postoperative plan OS:
Discontinue Regimen : Moxifloxacin
Modify Regimen : Decrease Prednisolone to 2x/day as scheduled
Decrease Ketorolac to 2x/day as scheduled

**Plan: Counseling - Postop Cataract Surgery.**
I counseled the patient regarding the following:
Eye Care: Most patients recovering from cataract surgery need various eye drops to prevent infection, reduce inflammation, and promote healing. These eye drops need to be used as prescribed, and it is also very important to keep your appointments for postoperative examinations. We also recommend taping a protective plastic eye shield over the eye every night at bedtime, for the first week.
Expectations: Most patients experience a significant improvement in vision by the first postoperative day, but it may take a few weeks for maximum improvement. Occasionally, blurry vision may be present on the first postoperative day for a variety of reasons including having had a hard cataract, corneal swelling, retinal swelling, and complicated surgery. The eye has a tremendous capacity to heal. Your eyeglass prescription usually changes after cataract surgery so your old eyeglasses won't be helpful. A new eyeglass prescription will usually be given after 3-4 weeks of healing.
Contact the office if: Contact the office for any pain, redness, flashing lights, floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.
Postoperative restrictions for cataract surgery patients include no strenuous activity for one week, including no golf, tennis, aerobics, weight lifting, bicycling, or sweating for one week. We also don't allow swimming or eye make up for two weeks after surgery.
----
Discussed will need glasses for BCVA due to astigmatism.

2. **Combined form of senile cataract OD**
(H25.811)

**Plan: Counseling - Cataracts.**
I counseled the patient regarding the following:
Visually significant: Patient elects to proceed with cataract surgery

Medical Decision Making - OD
Will proceed with second eye sx

**Plan: F/U for Next Visit Cataract.**
- as scheduled for sx

## Staff:

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 05/29/2024 10:05 AM PDT

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 05/29/2024 10:05 AM PDT

# Visit Note - June 12, 2024

PMS ID: Sex DOB MRN

## Medications
Reviewed and changes noted June 12, 2024.

OPHTHALMIC MEDICATIONS
ketorolac 0.5% drops
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension

NON OPHTHALMIC MEDICATIONS
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted June 12, 2024.
Cataract of right eye

## Ocular Surgery
H/O: L cataract extraction: 05.21.24 ( ) DISTANCE
H/O: R cataract extraction: 06.11.24 ( ) DISTANCE

## Social History
Reviewed June 12, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed June 12, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted June 12, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted June 12, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted June 12, 2024.
Total replacement of left knee joint

## Chief Complaint: 1 DAY s/p PCIOL OD distance

**HPI:** This is an 84 year old male who is being seen for a chief complaint of 1 DAY s/p PCIOL OD distance. Pt states that VA OD is still blurry. No eyes pain. . Pt uses Ketorolac QID OD /BID OS, Prednisolone QID OD /BID OS and Moxifloxacin QID OD as directed. s/p PCIOL OS. Pt states that he was told that he has astigmatisms. Pt states that he has feeling of FB sensation OS sometimes. Does not uses AT. Pt denies any other discomfort at this time.

## Eye Exam

### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | **20/60 -2**<br>**PH: 20/25 -2** |
| | OS | **20/60 +2**<br>**PH: 20/25 -2** |

### IOP

| | | |
|---|---|---|
| OD | 17 | 06/12/2024 03:33 PM PDT Applanation |
| OS | 13 | 06/12/2024 03:33 PM PDT Applanation |

## Exam:
An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: white and quiet

OD Cornea: clear cornea

OD Anterior Chamber: **cell trace**

OD Iris: normal iris without rubeosis

OD Lens: **PCIOL**

Ophthalmoscopic examination of optic disc OD:
OD: **CD ratio 0.45**
OD Optic Disc: **UNDILATED**

OS External: normal lid position, nasolacrimal and orbita exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet

OS Cornea: clear cornea

OS Anterior Chamber: deep and quiet anterior chamber

OS Iris: normal iris without rubeosis

OS Lens: **PCIOL**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. Postop Cataract OU
   (Z98.42 and Z98.41)
   Associated diagnosis: Presence of intraocular lens

   **Plan: Post Op Evaluation Cataract.**
   OD Postop: day 1
   OD Postop: 6/11/24
   I recommended the following postoperative plan OD:
   Continue Regimen : Use Moxifloxacin, Ketorolac and Prednisolone as scheduled.
   OS Postop: week 3
   OS Postop: 5/21/2024
   I recommended the following postoperative plan OS:
   Continue Regimen : Ketorolac and Prednisolone BID as scheduled

   **Plan: Counseling - Postop Cataract Surgery.**
   I counseled the patient regarding the following:

Eye Care: Most patients recovering from cataract surgery need various eye drops to prevent infection, reduce inflammation, and promote healing. These eye drops need to be used as prescribed, and it is also very important to keep your appointments for postoperative examinations. We also recommend taping a protective plastic eye shield over the eye every night at bedtime, for the first week.
Expectations: Most patients experience a significant improvement in vision by the first postoperative day, but it may take a few weeks for maximum improvement. Occasionally, blurry vision may be present on the first postoperative day for a variety of reasons including having had a hard cataract, corneal swelling, retinal swelling, and complicated surgery. The eye has a tremendous capacity to heal. Your eyeglass prescription usually changes after cataract surgery so your old eyeglasses won't be helpful. A new eyeglass prescription will usually be given after 3-4 weeks of healing.
Contact the office if: Contact the office for any pain, redness, flashing lights, floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.
Postoperative restrictions for cataract surgery patients include no strenuous activity for one week, including no golf, tennis, aerobics, weight lifting, bicycling, or sweating for one week. We also don't allow swimming or eye make up for two weeks after surgery.
----
Discussed will need glasses for BCVA due to astigmatism.

**Plan: Set Global Period.**
Location: OD
The following surgery was performed: Cataract Extraction
The surgery date was 06/11/2024.

## Follow Up

1. **Follow Up for Next Visit**

Instructions: AS SCHEDULED.

## Staff:

[REDACTED], OD (Primary Provider) (Bill Under)

[REDACTED]

[REDACTED]

[REDACTED] (scribe)

I, [REDACTED] am scribing for, and in the presence of [REDACTED], OD.

Electronically Signed By: [REDACTED], 06/12/2024 03:39 PM PDT

I, [REDACTED], OD, personally performed the services described in the documentation as scribed by [REDACTED] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [REDACTED], OD, 06/12/2024 03:39 PM PDT

# Visit Note - June 18, 2024

PMS ID: Sex DOB MRN

## Medications
Reviewed June 12, 2024.
OPHTHALMIC MEDICATIONS
ketorolac 0.5% drops
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension

NON OPHTHALMIC MEDICATIONS
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed June 12, 2024.
Cataract of right eye

## Ocular Surgery
H/O: L cataract extraction: 05.21.24 ( ) DISTANCE
H/O: R cataract extraction: 06.11.24 ( ) DISTANCE

## Social History
Reviewed June 12, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed June 12, 2024.
No known drug allergies

## Family History
Reviewed June 12, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed June 12, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed June 12, 2024.
Total replacement of left knee joint

## Chief Complaint: 1 week PO OD

**HPI:** This is an 84 year old male who is being seen for a chief complaint of 1 week PO OD. H/O: OS cataract extraction: 05.21.24 ( ) DISTANCE and OD: 06.11.24 ( ) DISTANCE.
Patient reports he noticed minimal VA difference OU. Denies any flashes but reports some floaters OU. Denies any pain, but states some discomfort OS occasionally (states that feels like he has some contact lens inserted).
Patient states he finished the drops on OS and is using Prednisolone and Ketorolac BID OD.

## Eye Exam

### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | **20/70 -2**<br>**PH: 20/30 -2** |
| | OS | **20/50 +1**<br>**PH: 20/25 -2** |

### IOP

| | | | |
|---|---|---|---|
| OD | **12** | 06/18/2024 09:02 AM PDT | Applanation |
| OS | **11** | 06/18/2024 09:02 AM PDT | Applanation |

## Exam:
An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: white and quiet
OD Cornea: clear cornea
OD Anterior Chamber: deep and quiet anterior chamber
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place**

OS External: normal lid position, nasolacrimal and orbita exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: clear cornea
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: **PCIOL in place, PCO**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. **Postop Cataract OU**
   (Z98.41 and Z98.42)
   Associated diagnosis: Presence of intraocular lens

   **Plan: Counseling - Postop Cataract Surgery.**
   I counseled the patient regarding the following:
   Contact the office if: Contact the office for any pain, redness, flashing lights, floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.
   ----
   Discussed will need glasses for BCVA due to astigmatism.

   **Plan: Post Op Evaluation Cataract.**
   OD Postop: week 1
   OD Postop: 6/11/24
   I recommended the following postoperative plan OD:
   Continue Regimen : Prednisolone and Ketorolac BID.
   OS Postop: month 1
   OS Postop: 5/21/2024
   I recommended the following postoperative plan OS:

Treatment Regimen : Finished with surgical drops

## Follow Up

### 1. Follow Up for Next Visit

Instructions: 4-6 months DFE.

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 06/18/2024 09:28 AM PDT

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 06/18/2024 09:28 AM PDT

# Visit Note - October 9, 2024

PMS ID: Sex DOB MRN

## Medications
Reviewed and changes noted October 9, 2024.

**OPHTHALMIC MEDICATIONS**
ketorolac 0.5% drops
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension

**NON OPHTHALMIC MEDICATIONS**
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted October 9, 2024.
Cataract of right eye

### Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE

## Social History
Reviewed October 9, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed October 9, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted October 9, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted October 9, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted October 9, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. DFE

## HPI: This is an 84 year old male who:
1. is being seen for a chief complaint of DFE. due to PCIOL OU. Patient has h/o cataract extraction done for OS: 05.21.24 ( ) DISTANCE and OD: 06.11.24 ( ) DISTANCE.
   Patient states that vision is still not that great, since is still needing to use glasses occasionally.
   Reports occasional floaters OU and denies any type flashes of light.
   Reports occasional tearing and denies any ocular pain and discomfort.
   Patient uses Refresh every day, but states that frequency really depends.

## Eye Exam

### Vision
Distance Test Type: Snellen Chart

| | Eye | |
|---|---|---|
| Dsc | OD | **20/80 -2**<br>**PH: 20/50 -2** |
| | OS | **20/50 +2**<br>**PH: 20/25 -2** |

### Wearing
Glasses
Eyeglass:
Usage: OTC readers

| Eye | Measurement | DCC | NCC |
|---|---|---|---|
| **OD** | **+1.50** | | |
| **OS** | **+1.50** | | |

### Pupils: Normal

| | Light (mm) | Dark (mm) | Near (mm) | Size | Round | Regular | Reacts | APD | RAPD | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| OD | | **2.00** | | Normal | Round | Regular | Reacts Well | No APD | | |
| OS | | **2.00** | | Normal | Round | Regular | Reacts Well | No APD | | |

### IOP

| | | | | |
|---|---|---|---|---|
| OD | **13** | | 10/09/2024 08:08 AM PDT | Applanation |
| OS | **13** | | 10/09/2024 08:08 AM PDT | Applanation |

### Diagnostic Drops

| | Drops Used | Staff | Date | Notes |
|---|---|---|---|---|
| OD | Tropicamide 1%/Phenylephrine 2.5%<br>Fluress | | 08:13 AM PDT | |
| OS | Tropicamide 1%/Phenylephrine 2.5%<br>Fluress | | 08:13 AM PDT | |

Patient counseled about blurry vision and problems driving after dilation.

### Motility: Full OU

### Cover-Uncover Test:

Recorded: 10/09/2024 08:08 AM PDT

| | |
|---|---|
| Near | |
| Distance | Ortho<br>Ortho |

**Visual Field Test Type:** Confrontation Visual Fields

**Visual Field Test Result: Full to Confrontation OU**

## Exam:

An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: white and quiet

OD Cornea: clear cornea

OD Anterior Chamber: deep and quiet anterior chamber

OD Iris: normal iris without rubeosis

OD Lens: **PCIOL in place, PCO**

A dilated exam of the optic disc was performed OD.

Ophthalmoscopic examination of optic disc OD:
OD: **CD ratio 0.45**
OD Optic Disc: flat and normal disc

A dilated fundus exam was performed OD.

Ophthalmoscopic examination of retina and vessels OD:
OD Vitreous: vitreous clear without hemorrhage, cells or pigment
OD Vessels: vessels with normal contour, caliber without neovascularization
OD Macula: **ERM, intraretinal fluid**
OD Periphery: periphery normal appearance without retinal tears, breaks, holes or mass

OS External: normal lid position, nasolacrimal and orbital exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet

OS Cornea: clear cornea

OS Anterior Chamber: deep and quiet anterior chamber

OS Iris: normal iris without rubeosis

OS Lens: **PCIOL in place, PCO**

A dilated exam of the optic disc was performed OS.

Ophthalmoscopic examination of optic disc OS:
OS: **CD ratio 0.45**
OS Optic Disc: flat and normal disc

A dilated fundus exam was performed OS.

Ophthalmoscopic examination of retina and vessels OS:
OS Vitreous: vitreous clear without hemorrhage, cells or pigment
OS Vessels: vessels with normal contour, caliber without neovascularization
OS Macula: **peripheral ERM**
OS Periphery: periphery normal appearance without retinal tears, breaks, holes or mass

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Tests

**OCT, Retinal**

A same-day order was placed for this diagnostic test.

Diagnostic Procedure: Retinal Optical Coherence Tomography - OU

Machine: Cirrus
Indication: Epiretinal Membrane OU

Findings OD: epiretinal membrane
Other Findings OD: macular edema
OCT Diagnosis OD: epiretinal membrane and macular edema
Findings OS: epiretinal membrane
OCT Diagnosis OS: epiretinal membrane
Reliability: good
Assessment OD: stable compared to previous study
Assessment OS: stable compared to previous study

## Impression/Plan:

1. **Epiretinal Membrane OU**
(H35.373)

**Plan: Counseling - Epiretinal membrane.**
I counseled the patient regarding the following:
Eye care: Epiretinal membranes do not usually require treatment, unless distorted vision or blurry vision occur. The main treatment consists of vitrectomy surgery with peeling off of the epiretinal membrane.
Expectations: Epiretinal membrane formation is often without symptoms or effect on vision. They occur from aging, previous eye trauma or surgery, or chronic eye inflammation (such as uveitis). In rare instances, they can progress and have a significant affect on vision.

After counseling the patient, we decided on the following plan for the left eye: Observation

2. **Clinically Significant Macular Edema OD** - *mac edema od with ERM*
*- will start pred/keto qid*
*- refer to*
*- will also perform yag cap to improve his view to the retina, od first*
unspecified diabetic type and mild OD (E13.3211)

**Plan: Prescription.**
**prednisolone acetate** 1 % **eye drops,suspension** Ophthalmic (eye)
**Location:** OD
**Sig:** Apply one drop in affected eye 4 times a day.
**Quantity:** 10 Milliliter **Refills:** 2 **Earliest fill date:** October 09, 2024

**ketorolac** 0.5 % **eye drops** Ophthalmic (eye)
**Location:** OD
**Sig:** Apply one drop in affected 4 times a day.
**Quantity:** 5 Milliliter **Refills:** 3 **Earliest fill date:** October 09, 2024

**Plan: Treatment Regimen.**
Start the following treatment(s): Prednisolone QID OD
Ketorolac QID OD.

3. **Irregular Astigmatism OU** - *? Forme Fuste Keratoconus given some inferior steepening*
(H52.213)

**Plan: Counseling - Irregular Astigmatism.**
I counseled the patient regarding the following:
Eye Care: Irregular astigmatism usually prevents someone from seeing clearly through eyeglasses, so hard or gas permeable contact lenses are a reliable way to improve one's vision. Refractive surgery such as LASIK and PRK are usually not successful in patients with irregular astigmatism. There are no reliable surgical treatments for irregular astigmatism.
Expectations: Irregular astigmatism is a condition comprised of an irregular corneal surface. It can be an inherited condition, or result from corneal scarring or previous ocular surgery. There is also a disease called keratoconus that may present with irregular astigmatism in its early stages
Contact office if: You experience loss of vision with your glasses or contact lenses, or notice that you need frequent changes in your eyeglass or contact lens prescriptions.

4. **Posterior Capsular Opacification OU**
(H26.493)

**Plan: Counseling - Posterior Capsular Opacification.**
I counseled the patient regarding the following:
Posterior capsular opacification often requires a YAG laser capsulotomy to remove the opacity and improve the vision.

--------------------
Posterior capsular opacification is very common after cataract surgery and can occur months to years later. There is no way to prevent its occurrence. It is due to lens epithelial cells that proliferate and coat the clear posterior capsule.
--------------------
Contact Office if: Posterior capsular opacification progresses and causes a loss of vision that affects your ability to read, drive a car, see street signs, watch TV, or follow the golf ball.

After counseling the patient, we decided on the following plan for the right eye: YAG laser posterior capsulotomy

After counseling the patient, we decided on the following plan for the left eye: YAG laser posterior capsulotomy

## Follow Up

### 1. Follow Up for Next Visit

Laser OD: YAG Laser Posterior Capsulotomy.
Laser OS: YAG Laser Posterior Capsulotomy.
Instructions: YAG Cap, OD first then OS.

Instructions: refer to Dr. [redacted] in 4-6 weeks for macular edema OD.

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted]

## Patient Referrals:

[redacted], D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 10/09/2024 10:07 AM PDT

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 10/09/2024 10:07 AM PDT

# Visit Note - October 15, 2024



## Medications

Reviewed October 9, 2024.

**OPHTHALMIC MEDICATIONS**

ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD

**NON OPHTHALMIC MEDICATIONS**

dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History

Cataract of right eye

### Ocular Surgery

History of left cataract extraction: 05.21.24 ( DISTANCE
History of right cataract extraction: 06.11.24 () DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24 ()

## Social History

Reviewed October 9, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies

Reviewed October 9, 2024.
No known drug allergies

## Family History

Reviewed October 9, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History

Reviewed October 9, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History

Reviewed October 9, 2024.
Total replacement of left knee joint

## Chief Complaints:

1. yag cap OD due to decreased vision

## HPI: This is an 84 year old male who:

1. is being seen for a chief complaint of yag cap OD due to decreased vision. .

## Impression/Plan:

1. **Posterior Capsular Opacification OD**
   (H26.491)

   **Plan: YAG Laser Posterior Capsulotomy.**
   Procedure: YAG Laser Posterior Capsulotomy - OD
   Anesthesia: proparacaine drops
   Complications: none
   The risks, benefits and alternatives of the procedure were discussed with the patient. The patient read and signed the consent form, was identified, and was seated at the laser slit lamp.Pre-treatment drops of Alphagan-P, phenylephrine 2.5%, and tropicamide 1% were given. Topical anesthesia was obtained with proparacaine drops. A YAG capsulotomy lens was applied to the eye. The YAG laser was employed for a total of 15 laser shots, with a power of 4.7 mJ, and 1 shots per burst, treating the central posterior capsule. The intraocular pressure was measured by deferred. The patient was instructed to continue using all the same eye drops as before the procedure. The patient was advised to call immediately for any pain, lid swelling or tenderness, discharge, or loss of vision.

## Staff:

, MD (Primary Provider) (Bill Under)

## Patient Referrals:

, D OD - Referring Provider

Electronically Signed By: , MD, 10/15/2024 08:54 AM PDT

Visit Note - October 22, 2024

PMS ID: Se- DOB MRN

## Medications

Reviewed and changes noted October 22, 2024.

**OPHTHALMIC MEDICATIONS**

ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD

**NON OPHTHALMIC MEDICATIONS**

dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History

Obtained and Reviewed October 22, 2024.
Cataract of right eye

## Ocular Surgery

History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24 ( )
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History

Reviewed October 22, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies

Reviewed October 22, 2024.
No known drug allergies

## Family History

Reviewed and no changes noted October 22, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History

Reviewed and no changes noted October 22, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History

Reviewed and no changes noted October 22, 2024.
Total replacement of left knee joint

## Chief Complaints:

1. Yag Cap OS

## HPI: This is an 84 year old male who:

1. is being seen for a chief complaint of Yag Cap OS. due to decreased vision.

## Eye Exam

### Diagnostic Drops

| | Drops Used | Staff | Date | Notes |
|---|---|---|---|---|
| OS | Tropicamide 1%/Phenylephrine 2.5%<br>Proparacaine 0.5% | Young, Mallory | 08:07 AM PDT | |

Patient counseled about blurry vision and problems driving after dilation.

## Impression/Plan:

1. **Posterior Capsular Opacification OS**
(H26.492)

**Plan: YAG Laser Posterior Capsulotomy.**
Procedure: YAG Laser Posterior Capsulotomy - OS
Anesthesia: proparacaine drops
Complications: none
The risks, benefits and alternatives of the procedure were discussed with the patient. The patient read and signed the consent form, was identified, and was seated at the laser slit lamp.Pre-treatment drops of Alphagan-P, phenylephrine 2.5%, and tropicamide 1% were given. Topical anesthesia was obtained with proparacaine drops. A YAG capsulotomy lens was applied to the eye. The YAG laser was employed for a total of 10 laser shots, with a power of 4.0 mJ, and 1 shots per burst, treating the central posterior capsule. The intraocular pressure was measured by deferred. The patient was instructed to continue using all the same eye drops as before the procedure. The patient was advised to call immediately for any pain, lid swelling or tenderness, discharge, or loss of vision.

## Staff:

, MD (Primary Provider) (Bill Under)

(scribe)

## Patient Referrals:

, D OD - Referring Provider

I, am scribing for, and in the presence of , MD.

Electronically Signed By: , 10/22/2024 09:08 AM PDT

I, MD, personally performed the services described in the documentation as scribed by in my presence, and confirm it is both accurate and complete.

Electronically Signed By: , MD, 10/22/2024 09:08 AM PDT

# Visit Note - October 29, 2024

PMS ID: Sex: DOB: MRN:

## Medications
Reviewed and no changes noted October 29, 2024.

**OPHTHALMIC MEDICATIONS**
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD

**NON OPHTHALMIC MEDICATIONS**
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted October 29, 2024.
Cataract of right eye

### Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed October 29, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed October 29, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted October 29, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted October 29, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted October 29, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. 1 week Yag cap PO OD

## HPI: This is an 84 year old male who:
1. is being seen for a chief complaint of 1 week Yag cap PO OD. YAG Cap OS : 10/22/2024 ( , YAG Cap OD: 10/15/24 ( ). S/p PC IOL OS: 05.21.24 ( ) DISTANCE, PC IOL OD: 06.11.24 ( ) DISTANCE. Patient states Saturday nights after he had eye drops at 11 ; 30 pm he noticed vision OD stared to get blurry. When he woke up Sunday vision was better. Patient report also having FB sensation OD since that day. Patient C/ o pain in the back of de OD that come and goes. Patient taking ketorolac ,prednisolone OD TID.

## Eye Exam

### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | **20/80**<br>**PH: 20/30 -2** |
| | OS | **20/30 -2**<br>**PH: 20/25 -2** |

### IOP
| | |
|---|---|
| OD | **14** |
| OS | **11** |

### Diagnostic Drops

| | Drops Used | Staff |
|---|---|---|
| OD | Proparacaine 0.5% | |

## Exam:
An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam

OD Lid Margin: quiet and normal

Slit lamp examination OD:

OD Conjunctiva: white and quiet

OD Cornea: clear cornea

OD Anterior Chamber: deep and quiet anterior chamber

OD Iris: normal iris without rubeosis

OD Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. **Postop YAG Capsulotomy OU**
(Z98.890)

**Plan: Counseling - Postop YAG Capsulotomy.**
I counseled the patient regarding the following:
Contact the office if: Contact the office for any pain, redness, flashing lights, hundreds of new floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.

**Plan: Post Op Evaluation YAG Capsulotomy.**
OD Postop: 10/15/24
I recommended the following postoperative plan OD:
Continue Regimen : Normal regimen. No restrictions.
OS Postop: 10/22/24
I recommended the following postoperative plan OS:
Continue Regimen : Normal regimen. No restrictions.

2. **Clinically Significant Macular Edema OD** - *mac edema od with ERM*
   *- cont pred/keto qid*
   *- refer to dr [redacted] ---> pt has upcoming appt*

   unspecified diabetic type and mild OD (E13.3211)

   **Plan: Treatment Regimen.**
   Continue the following treatment(s): Prednisolone QID OD
   Ketorolac QID OD.

## Follow Up

1. **Follow Up for Next Visit**

   Instructions: 6 months DFE with Mac OCT.

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] scribe)

## Patient Referrals:

[redacted], D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 10/29/2024 08:25 AM PDT

I, [redacted] MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 10/29/2024 08:25 AM PDT

Visit Note - October 30, 2024

PMS ID: Sex DOB MRN

## Medications
Reviewed October 29, 2024.

OPHTHALMIC MEDICATIONS

ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD

NON OPHTHALMIC MEDICATIONS

dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed October 29, 2024.
Cataract of right eye

### Ocular Surgery
History of left cataract extraction: 05.21.24 (KAS) DISTANCE
History of right cataract extraction: 06.11.24 DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed October 29, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed October 29, 2024.
No known drug allergies

## Family History
Reviewed October 29, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed October 29, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed October 29, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. Pain OD evaluation

## HPI: This is an 84 year old male who:
1. is being seen for a chief complaint of Pain OD evaluation. Pt states that he has been having pain OD since this morning. Pt states that when he touch his eye it is hurts. Pt states that he is not able to see out of OD today, has noticed VA change last night , and getting worse. Pt states that has issue with light sensitivity and watering OD. Pt c/o headaches on the right side. Pt states that it is something new. Pt saw dr yesterday . Pt was told to continue with Prednisolone and Ketorolac QID OD. Pt has hx of YAG Cap OS : 10/22/2024 ( ), YAG Cap OD: 10/15/24 ( ). S/p PC IOL OS: 05.21.24 ( DISTANCE, PC IOL OD: 06.11.24 DISTANCE. Pt denies any other discomfort at this time. Scheduled appointment with retina specialist on 11/15/24.

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | **HM**<br>**PH: NI** |
| | OS | **20/40**<br>**PH: NI** |

### IOP

| | | | | |
|---|---|---|---|---|
| OD | 20 | | 10/30/2024 01:26 PM PDT | Tonopen<br>due to pain and redness |
| OS | | | 10/30/2024 01:26 PM PDT | Tonopen |

## Exam:
An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam

OD Lid Margin: quiet and normal

Slit lamp examination OD:

OD Conjunctiva: **diffuse sub conj heme/ injection**

OD Cornea: **contact lens present, 2+ DM folds, epi defect 1x3mm**

OD Anterior Chamber: **less than 1mm hypopyon**

OD Iris: normal iris without rubeosis

OD Lens: **PCIOL in place, open PC**

OS External: normal lid position, nasolacrimal and orbita exam

OS Lid Margin: quiet and normal

Slit lamp examination OS:

OS Conjunctiva: white and quiet

OS Cornea: clear cornea

OS Anterior Chamber: deep and quiet anterior chamber

OS Iris: normal iris without rubeosis

OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Data Reviewed:
3 Ordering of each unique test (Bacteria identified in Eye by Anaerobe+Aerobe culture, Bacteria identified in Eye by Aerobe culture, Fungus identified in Skin by Culture)

## Tests

**Corneal Scraping Diagnostic**

A same-day order was placed for this diagnostic test.

Procedure: Corneal Scraping Diagnostic - OD
Indication: Central Corneal Ulceration OD
Anesthesia: proparacaine gtts
Complications: none
The risks, benefits and alternatives of the procedure were discussed with the patient. The patient read and signed the consent form, was identified, and was seated at the slit lamp.Topical anesthesia was obtained with proparacaine gtts and a sterile cotton swab was used to scrape the corneal ulcer bed and plate cultures directly on blood agar, chocolate agar, and Sabouraud's agar. Cultures were submitted to an outside microbiology lab..The patient tolerated the procedure well, and was told to return to clinic tomorrow. The patient was advised to call immediately for any pain, lid swelling or tenderness, discharge, or loss of vision.

## Impression/Plan:

1. **Central Corneal Ulceration OD** - *Corneal infection OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
   *- Corneal cultures taken of BCL and cornea by Dr. . Discussed case with*
   *- Quest pick up conf# 177925934*

   *D/c Prednisolone and Ketorolac*

   *Start Moxifloxacin q1H OD through the night. Discontinue once fortified Abx are ready.*

   *Start Fortified Vancomycin 25mg/ml every 1 hour around the clock (called in to metapharmacy)*
   *Start Fortified Tobramycin 15mg/ ml every 1 hour around the clock (called in to metapharmacy)*

   *Start Doxycyline 50 mg BID po*
   *Start Cyclopentolate TID OD*
   *Start Vitamin C 1,000mg (OTC)*
   (H16.011)
   Pain Intensity: 3.0 - 3/10 Pain

   **Plan: Counseling - Corneal Ulcer.**
   Please refer to the education handout for detailed counseling.

   After counseling the patient, we decided on the following plan for the right eye: Corneal Scraping

   **Plan: Treatment Regimen.**
   Start the following treatment(s): —
   Fortified Vancomycin 25mg/ml every 1 hour around the clock (called in to metapharmacy)
   Fortified Tobramycin 15mg/ ml every 1 hour around the clock (called in to metapharmacy)

   Moxifloxacin Q1HR OD --> switch to fortified when ready to pick up
   Cyclopentolate TID OD
   Doxycycline 50mg BID PO
   Vitamin C 1,000mg (OTC)

   **Plan: Order Tests.**
   Labs:
   609-8 - Bacteria identified in Eye by Aerobe culture
   74816-0 - Bacteria identified in Eye by Anaerobe+Aerobe culture
   575-1 - Fungus identified in Skin by Culture

   **Plan: Prescription.**
   **moxifloxacin 0.5 % eye drops** Ophthalmic (eye)
   **Sig:** instill 1 drop into the right eye once every hour, until able to get fortified drops from meta pharmacy
   **Quantity:** 3 Milliliter **Earliest fill date:** October 30, 2024

   **doxycycline monohydrate 50 mg tablet** PO

**Sig**: take one tablet by mouth twice a day
**Quantity**: 60 Tablet **Earliest fill date**: October 30, 2024

**cyclopentolate 0.5 % eye drops** Ophthalmic (eye)
**Location**: OD
**Sig**: instill one drop into right eye three times a day
**Quantity**: 15 Milliliter **Earliest fill date**: October 30, 2024

2. **Postop YAG Capsulotomy OU**
(Z98.890)

**Plan: Counseling - Postop YAG Capsulotomy.**
I counseled the patient regarding the following:
Contact the office if: Contact the office for any pain, redness, flashing lights, hundreds of new floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.

**Plan: Post Op Evaluation YAG Capsulotomy.**
OD Postop: 10/15/24
I recommended the following postoperative plan OD:
Continue Regimen : Ok to use ATs. No restrictions.
OS Postop: 10/22/24
I recommended the following postoperative plan OS:
Continue Regimen : Ok to use ATs. No restrictions.

3. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted] given corneal compromise, advised to discontinue medication until cornea recovers.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
Refer to retina specialist/ pending appt with Dr. [redacted]

**Plan: Treatment Regimen.**
Discontinue the following treatment(s): hold off om using Ketorolac and prednisolone gtt at this time.

## Follow Up

1. **Follow Up for Next Visit**

Instructions: RTC tomrrow with [redacted] urgent please override.

## Staff:

[redacted], OD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted] D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], OD.

Electronically Signed By: [redacted], 10/30/2024 04:24 PM PDT

I, [redacted], OD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted] OD, 10/30/2024 04:24 PM PDT

# Visit Note - October 31, 2024



## Medications
Obtained and Reviewed November 1, 2024.

**OPHTHALMIC MEDICATIONS**
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted November 1, 2024.
Cataract of right eye

### Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed November 1, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 1, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted November 1, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted November 1, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted November 1, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. Cornea follow up

## HPI: This is an 84 year old male who:
1. is being seen for a chief complaint of Cornea follow up. Patient is here for central corneal ulceration OD. He states they found a contact in OD yesterday at SW office. Right ey has not been feeling good for a while, on Sunday his right eye got worse and by Tuesday it was getting even worse, saw Dr. Tuesday but was told everything was fine. Yesterday (wednesday) was seen by Dr. who consulted with Dr. who found a BCL in OD and told right eye has infection, cultures were also done for right eye.
   Fortified drops coming tomorrow morning so pt has not started yet.
   Started Moxifloxacin q1H OD through the night and Started Doxycyline 50 mg BID po, also Started Vitamin C 1,000mg (OTC)
   Didn't start Cyclopentolate because the Pharmacy did not have it.

   Will Start Fortified Vancomycin 25mg/ml every 1 hour around the clock (called in to metapharmacy) tomorrow
   Will Start Fortified Tobramycin 15mg/ ml every 1 hour around the clock (called in to metapharmacy) tomorrow

## Eye Exam
### Vision
Distance Test Type: Snellen Chart    Distance Correction Type: None

| Dsc | OD | HM |
|---|---|---|
| | OS | 20/50<br>PH: 20/40 |

## Exam:
An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **diffuse sub conj heme/ injection**
OD Cornea: **dense infiltrate10mmx6mm nasally**
OD Anterior Chamber: **2mm hypopyon with fibrin**
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place, open PC**

OS External: normal lid position, nasolacrimal and orbita exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: clear cornea
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
   *- Corneal cultures taken of BCL and cornea by Dr. . Discussed case with .*
   *- Quest pick up conf# 177925934*
   *-D/c Prednisolone and Ketorolac*
   *See treatment plan for drops*

*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*Given worsening will inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*
(H16.011)
Pain Intensity: 3.0 - 3/10 Pain

**Plan: Counseling - Corneal Ulcer.**
Please refer to the education handout for detailed counseling.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Start the following treatment(s): ---
START Tobramycin gtt every 1 hr OD --> until able to get fortified picked up

Will be ready for pick up 11/1/2024:
Fortified Vancomycin 25mg/ml every 1 hour around the clock (called in to metapharmacy 10/30/2024)
Fortified Tobramycin 15mg/ ml every 1 hour around the clock (called in to metapharmacy 10/30/204).
Continue the following treatment(s): Moxifloxacin Q1HR OD --> until able to get fortified picked up
Doxycycline 50mg BID PO
Vitamin C 1,000mg (OTC).
Discontinue the following treatment(s): unable to get Cyclopentolate TID OD.

**Plan: Subconjunctival Injection.**
The initial decision to perform this procedure was made after evaluation during this visit.

Procedure: Subconjunctival Injection of cefazolin 50 mcg/ml

Lot number:
Expiration date:
Location: OD

Indication: Other

Anesthesia: proparacaine gtts and subconjunctival (1% lidocaine)

Complications: none

The risks, benefits and alternatives of the procedure were discussed with the patient. The patient read and signed the consent form and verbalized full understanding. The patient was identified and timeout confirmed the correct eye for the procedure. The patient was positioned appropriately. proparacaine gtts and subconjunctival (1% lidocaine) were employed to obtain adequate anesthesia. No complications At 1 o'clock, was injected subconjunctival.
The patient tolerated the procedure well and an ophthalmic patch was placed on the eye.

**Plan: Prescription.**
**tobramycin 0.3 % eye drops** Ophthalmic (eye)
**Sig:** Instill 1 drop into the right eye once every 1 hour
**Quantity:** 10 Milliliter **Refills:** 2 **Earliest fill date:** October 31, 2024

2. **Postop YAG Capsulotomy OU**
(Z98.890)

**Plan: Counseling - Postop YAG Capsulotomy.**
I counseled the patient regarding the following:
Contact the office if: Contact the office for any pain, redness, flashing lights, hundreds of new floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.

**Plan: Post Op Evaluation YAG Capsulotomy.**
OD Postop: 10/15/24
I recommended the following postoperative plan OD:
Continue Regimen : No restrictions.
OS Postop: 10/22/24
I recommended the following postoperative plan OS:

Continue Regimen : No restrictions.

3. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted] given corneal compromise, advised to discontinue medication until cornea recovers.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
Refer to retina specialist/ pending appt with Dr. [redacted]

**Plan: Treatment Regimen.**
Discontinue the following treatment(s): hold off om using Ketorolac and prednisolone gtt at this time.

## Follow Up

1. **Follow Up for Next Visit**

Instructions: RTC tomorrow HN office with [redacted] urgent please override.

## Staff:

[redacted]

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted], D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 11/01/2024 05:46 PM PDT

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted] MD, 11/01/2024 05:46 PM PDT

Visit Note - November 1, 2024

PMS ID: Sex DOB PRN

## Medications
Reviewed and changes noted November 1, 2024.

**OPHTHALMIC MEDICATIONS**
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted November 1, 2024.
Cataract of right eye

## Ocular Surgery
History of left cataract extraction: 05.21.24 ) DISTANCE
History of right cataract extraction: 06.11.24 DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24 )
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed November 1, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 1, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted November 1, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted November 1, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted November 1, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. Follow up for central corneal ulceration OD

## HPI: This is an 84 year old male who:
1. is being seen for a chief complaint of Follow up for central corneal ulceration OD. Patient reports that they are doing okay. Denies pain but did mention that when they look at a certain direction they do have slight discomfort. Denies any vision changes, reports that VA is not good. Patient is taking

   -- Doxycycline 50mg BID PO
   -- Fortified Vancomycin Qhr1 OD
   -- Fortified Tobramycin Q1hr OD
   -- Tobramycin Qhr OD (along w/ fortified)

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| Dsc | OD | **HM** |
|---|---|---|
| | OS | **20/60 +2**<br>**PH: 20/25 -2** |

## Exam:
An examination was performed

| OD | OS |
|---|---|
| OD External: normal lid position, nasolacrimal and orbital exam | OS External: normal lid position, nasolacrimal and orbita exam |
| OD Lid Margin: quiet and normal | OS Lid Margin: quiet and normal |
| Slit lamp examination OD: | Slit lamp examination OS: |
| OD Conjunctiva: **diffuse sub conj heme/ injection** | OS Conjunctiva: white and quiet |
| OD Cornea: **dense infiltrate10mmx6mm nasally -- much less "goopy" discharge now; ++ associated epi defect over the infiltrate** | OS Cornea: clear cornea |
| OD Anterior Chamber: **2mm hypopyon; Fibrin almost resolved** | OS Anterior Chamber: deep and quiet anterior chamber |
| OD Iris: normal iris without rubeosis | OS Iris: normal iris without rubeosis |
| OD Lens: **PCIOL in place, open PC** | OS Lens: **PCIOL in place, open PC** |

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
   *- Corneal cultures taken of BCL and cornea by Dr. Discussed case with*
   *- Quest pick up conf# 177925934*
   *-D/c Prednisolone and Ketorolac*
   *See treatment plan for drops*

   *10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*

*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommnded inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommnded another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*
(H16.011)

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy.
Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Continue the following treatment(s): Moxifloxacin Q1HR OD
Doxycycline 50mg BID PO
Fortified Tobramycin 15mg/ ml every 1 hour around the clock.
Modify the following treatment(s): Fortified Vancomycin 25mg/ml every 2 hour around the clock .
Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).

**Plan: Subconjunctival Injection.**
The initial decision to perform this procedure was made after evaluation during this visit.

Procedure: Subconjunctival Injection of cefazolin 50 mcg/ml

Lot number:
Expiration date:
Location: OD

Indication: Other

Anesthesia: proparacaine gtts and subconjunctival (1% lidocaine)

Complications: none

The risks, benefits and alternatives of the procedure were discussed with the patient. The patient read and signed the consent form and verbalized full understanding. The patient was identified and timeout confirmed the correct eye for the procedure. The patient was positioned appropriately. proparacaine gtts and subconjunctival (1% lidocaine) were employed to obtain adequate anesthesia. No complications At 1 o'clock, was injected subconjunctival.
The patient tolerated the procedure well and an ophthalmic patch was placed on the eye.

2. **Postop YAG Capsulotomy OU**
(Z98.890)

**Plan: Counseling - Postop YAG Capsulotomy.**
I counseled the patient regarding the following:
Contact the office if: Contact the office for any pain, redness, flashing lights, hundreds of new floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.

**Plan: Post Op Evaluation YAG Capsulotomy.**
OD Postop: 10/15/24
I recommended the following postoperative plan OD:
Continue Regimen : No restrictions.
OS Postop: 10/22/24

I recommended the following postoperative plan OS:
Continue Regimen : No restrictions.

3. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted], given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
pending appt with Dr. [redacted]

## Follow Up

1. **Follow Up for Next Visit**

Instructions: RTC on Monday at 4pm with [redacted] at [redacted] for follow up.

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted], D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 11/01/2024 05:45 PM PDT

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 11/01/2024 05:45 PM PDT

# Visit Note - November 4, 2024

PMS ID: Sex DOB MRN

## Medications
Reviewed and changes noted November 4, 2024.

OPHTHALMIC MEDICATIONS
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

NON OPHTHALMIC MEDICATIONS
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted November 4, 2024.
Cataract of right eye

## Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024

## Social History
Reviewed November 4, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 4, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted November 4, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted November 4, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted November 4, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. 3 day cornea follow up

## HPI: This is an 84 year old male who:
1. is being seen for a chief complaint of 3 day cornea follow up. Pt states no changes to va, OU. Pt reports still having occasional pain, OD when moving eyes in certain direction. Pt is compliant with drops, OU and Doxycycline. H/O Central Corneal Ulceration OD. H/O Macular Edema OD. H/O PCIOL, OU. H/O YAG CAP, OU.

   Moxifloxacin Q1h OD
   Fortified Tobramycin Q1H OD
   Fortified Vancomycin Q2H OD
   Doxycycline 50mg BID PO
   Vitamin C 1000mg

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| Dsc | OD | **HM** |
|---|---|---|
| | OS | **20/60 +1**<br>**PH: 20/40 +2** |

## Exam:
An examination was performed

OD External: **NV on lid margin**

OD Lid Margin: **debris on lid**

Slit lamp examination OD:

OD Conjunctiva: **3-4+ injection**

OD Cornea: **dense infiltrate10mmx6mm nasally -- much less "goopy" discharge now; ++ associated epi defect over the infiltrate**

OD Anterior Chamber: **2mm hypopyon; Fibrin almost resolved**

OD Iris: normal iris without rubeosis

OD Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Tests
**Slit Lamp Photos**

Diagnostic Procedure: Slit Lamp Photos - OU
Indication: Central Corneal Ulceration OD

Findings OD: corneal ulcer
Findings OS: normal
Diagnoses OD: corneal ulcer
Diagnoses OS: normal
Reliability: good
Assessment: stable compared to previous study

## Impression/Plan:

1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
   *- Corneal cultures taken of BCL and cornea by Dr. [redacted] Discussed case with [redacted]*
   *- Quest pick up conf# 177925934*
   *-D/c Prednisolone and Ketorolac*
   *See treatment plan for drops*

   *10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
   *Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
   *Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
   *recommnded inject sub-conj 50 mcg/ml of Cefazolin -- done*
   *Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
   *Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

   *11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
   *Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
   *Recommnded another inject sub-conj 50 mg/ml of Cefazolin -- done today*
   *Slit lamp photos taken today*

   *11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*
   *Plan for f/u with [redacted] on Wed 11/6 and f/u with PMO on Friday 11/8*
   (H16.011)

   **Plan: Counseling - Corneal Ulcer.**
   I counseled the patient regarding the following:
   Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
   Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
   Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy.
   Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

   Medical Decision Making - OD
   treatment regimen

   **Plan: Treatment Regimen.**
   Continue the following treatment(s): Moxifloxacin Q1HR OD
   Doxycycline 50mg BID PO
   Fortified Tobramycin 15mg/ ml every 1 hour around the clock
   Fortified Vancomycin 25mg/ml every 2 hour around the clock.
   Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).

2. **Postop YAG Capsulotomy OU**
   (Z98.890)

   **Plan: Counseling - Postop YAG Capsulotomy.**
   I counseled the patient regarding the following:
   Contact the office if: Contact the office for any pain, redness, flashing lights, hundreds of new floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.

   **Plan: Post Op Evaluation YAG Capsulotomy.**
   OD Postop: 10/15/24
   I recommended the following postoperative plan OD:
   Continue Regimen : No restrictions.
   OS Postop: 10/22/24
   I recommended the following postoperative plan OS:

Continue Regimen : No restrictions.

3. **Macular Edema OD** - *macular edema OU - previously noted by Dr. given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
pending appt with Dr.

## Follow Up

1. **Follow Up for Next Visit**

Instructions: RTC this Wednesday with and with on Friday.

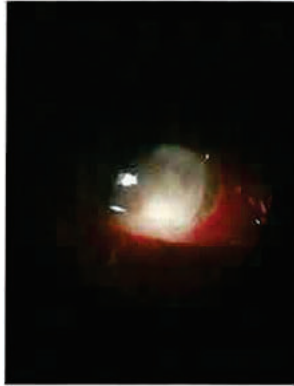
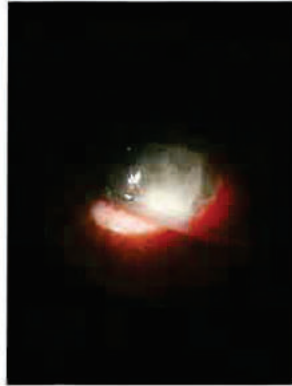
## Staff:

, MD (Primary Provider) (Bill Under)

(scribe)

## Patient Referrals:

, D OD - Referring Provider

| Other Photos | | |
|---|---|---|
|  od 1 |  od 2 | |

I, am scribing for, and in the presence of , MD.

Electronically Signed By: , 11/04/2024 05:25 PM PST

I, , MD, personally performed the services described in the documentation as scribed by in my presence, and confirm it is both accurate and complete.

Electronically Signed By: , MD, 11/04/2024 05:25 PM PST

# Visit Note - November 6, 2024



## Medications
Reviewed and no changes noted November 6, 2024.

**OPHTHALMIC MEDICATIONS**
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted November 6, 2024.
Cataract of right eye

## Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed November 6, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 6, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted November 6, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted November 6, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted November 6, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. F/U

## HPI: This is an 84 year old male who:
1. is being seen for a chief complaint of F/U. Central Corneal Ulceration OD and Macular Edema OD, s/p PCIOL, YAG CAP, OU. PT states that he has not noticed a change in VA OU. PT states some irritation and pain. Pt has been noticing some tearing.
   Pt is using Moxifloxacin Q1h OD, Fortified Tobramycin Q1H OD, Fortified Vancomycin Q2H OD, Doxycycline 50mg BID PO, Vitamin C 1000mg

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| Dsc | OD | **HM**<br>**PH: NI** |
|---|---|---|
| | OS | **20/60 -2**<br>**PH: 20/50 +2** |

## Exam:
An examination was performed

OD External: **NV on lid margin**
OD Lid Margin: **debris on lid**

OS External: normal lid position, nasolacrimal and orbita exam

Slit lamp examination OD:
OD Conjunctiva: **3-4+ injection**
OD Cornea: **less dense infiltrate10mmx6mm nasally -- much less discharge now; ++ associated epi defect over the infiltrate (see EMA photos tab)**

OD Anterior Chamber: **2mm hypopyon; Fibrin almost resolved**

OD Iris: normal iris without rubeosis

OD Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Tests
**Slit Lamp Photos**

Diagnostic Procedure: Slit Lamp Photos - OU
Indication: Central Corneal Ulceration OD

Findings OD: corneal ulcer
Findings OS: normal

Diagnoses OD: corneal ulcer
Diagnoses OS: normal
Reliability: good
Assessment: stable compared to previous study

## Impression/Plan:

1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
   *- Corneal cultures taken of BCL and cornea by Dr Discussed case with*
   *- Quest pick up conf# 177925934*
   *-D/c Prednisolone and Ketorolac*
   *See treatment plan for drops*

   *10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
   *Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
   *Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
   *recommnded inject sub-conj 50 mcg/ml of Cefazolin -- done*
   *Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
   *Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

   *11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
   *Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
   *Recommnded another inject sub-conj 50 mg/ml of Cefazolin -- done today*
   *Slit lamp photos taken today*

   *11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*

   *11/06/24: Slight improvement in hyphema, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*
   (H16.011)

   **Plan: Counseling - Corneal Ulcer.**
   I counseled the patient regarding the following:
   Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
   Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
   Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy.
   Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

   Medical Decision Making - OD
   treatment regimen

   **Plan: Treatment Regimen.**
   Continue the following treatment(s): Moxifloxacin Q1HR OD
   Doxycycline 50mg BID PO
   Fortified Tobramycin 15mg/ ml every 1 hour around the clock
   Fortified Vancomycin 25mg/ml every 2 hour around the clock.
   Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).

2. **Postop YAG Capsulotomy OU**
   (Z98.890)

   **Plan: Counseling - Postop YAG Capsulotomy.**
   I counseled the patient regarding the following:
   Contact the office if: Contact the office for any pain, redness, flashing lights, hundreds of new floaters, loss of vision, discharge, or double vision. Some postoperative complications can occur weeks to months after surgery.

   **Plan: Post Op Evaluation YAG Capsulotomy.**
   OD Postop: 10/15/24
   I recommended the following postoperative plan OD:
   Continue Regimen : No restrictions.
   OS Postop: 10/22/24
   I recommended the following postoperative plan OS:
   Continue Regimen : No restrictions.

3. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted] given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
pending appt with Dr. [redacted]

## Follow Up

1. **Follow Up for Next Visit**

Instructions: as scheduled 11.08.24 w/ [redacted].

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

## Patient Referrals:

[redacted], D OD - Referring Provider

Electronically By: , MD, 11/06/2024 PM PST

# Visit Note - November 8, 2024

PLS ID: Sex DOB

## Medications
Reviewed and no changes noted November 8, 2024.

**OPHTHALMIC MEDICATIONS**
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted November 8, 2024.
Cataract of right eye

## Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024

## Social History
Reviewed November 8, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 8, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted November 8, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted November 8, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted November 8, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. f/u

## HPI: This is an 84 year old male who:
1. is being seen for a chief complaint of f/u. Pt states that everything is about the same. Pt states that he has a pain OD ( number 3 on the scale of 1-10). Pt c/o discharge and tearing all the time" splash some water to remove that". Pt state that he feels relive when he close his OD. Uses readers only. Pt states that OS is fine. Pt uses Moxifloxacin Q1HR OD ,Doxycycline 50mg BID PO, Fortified Tobramycin 15mg/ ml every 1 hour around the clock, Fortified Vancomycin 25mg/ml every 2 hour around the clock. and Vitamin C 1,000mg . Pt denies any other discomfort at this time.

## Eye Exam

### Vision
Distance Test Type: Snellen Chart

| Dsc | OD | **HM** |
|---|---|---|
| | OS | **20/60**<br>**PH: 20/50 +2** |

### IOP

| | | | | |
|---|---|---|---|---|
| OD | **Deferred** | | 11/08/2024 04:14 PM PST | Applanation due to pain |
| OS | **Deferred** | | 11/08/2024 04:14 PM PST | Applanation due to OD issue |
| OD | **30** | MD | 11/08/2024 04:39 PM PST | Applanation |
| OS | | MD | 11/08/2024 04:39 PM PST | Applanation |

### Exam:
An examination was performed

OD External: **NV on lid margin**

OD Lid Margin: **debris on lid**

OS External: normal lid position, nasolacrimal and orbita exam

OS Lid Margin: quiet and normal

Slit lamp examination OD:

OD Conjunctiva: **2+ injection**

OD Cornea: **less dense infiltrate 6mmx4.5mm nasally -- much less discharge now; ++ associated epi defect over the infiltrate, diffuse PEE's**

OD Anterior Chamber: **2mm hypopyon inferonasal**

OD Iris: normal iris without rubeosis

OD Lens: **PCIOL in place, open PC**

Slit lamp examination OS:

OS Conjunctiva: white and quiet

OS Cornea: clear cornea

OS Anterior Chamber: deep and quiet anterior chamber

OS Iris: normal iris without rubeosis

OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*

, MD (Primary Provider) (Bill Under)

*- Corneal cultures taken of BCL and cornea by Dr. [redacted]. Discussed case with [redacted].*
*- Quest pick up conf# 177925934*
*-D/c Prednisolone and Ketorolac*
*See treatment plan for drops*

*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommnded inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommnded another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*

*11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*

*11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*

*11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*
(H16.011)

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy.
Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Start the following treatment(s): Dorzolamide BID OD
Alphagan BID OD.
Continue the following treatment(s): Moxifloxacin Q3HR OD
Doxycycline 50mg BID PO
Fortified Tobramycin 15mg/ ml every 1 hour around the clock
Fortified Vancomycin 25mg/ml every 3 hour around the clock.
Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).

**Plan: Prescription.**
**dorzolamide 2 % eye drops** Ophthalmic (eye)
**Location:** OD
**Sig:** Instill one drop into the right eye twice daily
**Quantity:** 10 Milliliter **Refills:** 2

**brimonidine 0.2 % eye drops** Ophthalmic (eye)
**Location:** OD
**Sig:** instill one drop into the right eye twice daily.
**Quantity:** 10 Milliliter **Refills:** 2

**2.** **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted] given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the

underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
pending appt with Dr.

## Follow Up

### 1. Follow Up for Next Visit

Instructions: 11.11.24 follow up w/

## Staff:

, MD (Primary Provider) (Bill Under)

(scribe)

## Patient Referrals:

, D OD - Referring Provider

I, am scribing for, and in the presence of , MD.

Electronically Signed By: , 11/08/2024 04:58 PM PST

I, , MD, personally performed the services described in the documentation as scribed by in my presence, and confirm it is both accurate and complete.

Electronically Signed By: , MD, 11/08/2024 04:58 PM PST

## Diagnosis Comment

Central Corneal Ulceration OD - Slight improvement in HYPOPYON, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen

Electronically Signed By: [redacted], MD, 11/08/2024 04:47 PM PST

# Visit Note - November 11, 2024



## Medications
Reviewed November 8, 2024.

**OPHTHALMIC MEDICATIONS**
brimonidine 0.2% drops OD
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed November 8, 2024.
Cataract of right eye

### Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24 (
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed November 8, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 8, 2024.
No known drug allergies

## Family History
Reviewed November 8, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed November 8, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed November 8, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. Corneal ulcer OD

## HPI: This is an 84 year old male who:
1. is being seen for a chief complaint of Corneal ulcer OD. 3 day return for follow up. Pt states no changes in OU VA, some pain with eye movement OD. Pt states using all prescribed medication except dorzolamide, not available at CVS, pts daughter aware she will have to use another pharmacy.

   Dorzolamide OD BID has not been filled yet
   Alphagan BID OD.
   Moxifloxacin Q3HR OD
   Doxycycline 50mg BID PO
   Fortified Tobramycin 15mg/ ml every 1 hour around the clock
   Fortified Vancomycin 25mg/ml every 3 hour around the clock.
   Vitamin C 1,000mg (OTC)

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | **HM**<br>**PH: NI** |
| | OS | **20/60 -1**<br>**PH: 20/40 -2** |

### IOP
OD **Deferred** 11/11/2024 04:01 PM PST Tonopen

## Exam:
An examination was performed

OD External: **NV on lid margin**
**slight ectropion LL**
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **3+ injection**

OD Cornea: **less dense infiltrate 6mmx4.5mm nasally -- much less discharge now; ++ associated epi defect over the infiltrate, diffuse PEE's**

OD Anterior Chamber: **2mm hypopyon inferonasal**

OD Iris: normal iris without rubeosis

OD Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Tests

**Slit Lamp Photos**

A same-day order was placed for this diagnostic test.

Diagnostic Procedure: Slit Lamp Photos - OD
Indication: Central Corneal Ulceration OD

Other Findings OD: Central Corneal Ulceration
Other Diagnoses OD: Central Corneal Ulceration
Reliability: good
Assessment: stable compared to previous study

## Impression/Plan:

1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
   *- Corneal cultures taken of BCL and cornea by Dr. [redacted] Discussed case with [redacted]*
   *- Quest pick up conf# 177925934*
   *-D/c Prednisolone and Ketorolac*
   *See treatment plan for drops*

   *10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
   *Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
   *Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
   *recommnded inject sub-conj 50 mcg/ml of Cefazolin -- done*
   *Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
   *Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

   *11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
   *Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
   *Recommnded another inject sub-conj 50 mg/ml of Cefazolin -- done today*
   *Slit lamp photos taken today*

   *11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*

   *11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*

   *11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*

   *11.11.24: slight improvement on todays exam. Patient to continue all drops as directed and return on Friday for follow up.*
   (H16.011)

   **Plan: Counseling - Corneal Ulcer.**
   I counseled the patient regarding the following:
   Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
   Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
   Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy.
   Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

   Medical Decision Making - OD
   treatment regimen

   **Plan: Treatment Regimen.**
   Continue the following treatment(s): Moxifloxacin Q3HR OD
   Doxycycline 50mg BID PO
   Fortified Tobramycin 15mg/ ml every 1 hour around the clock when awake
   Fortified Vancomycin 25mg/ml every 3 hour around the clock when awake
   Dorzolamide BID OD
   Alphagan BID OD.
   Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
pending appt with Dr.

## Follow Up

1. **Follow Up for Next Visit**

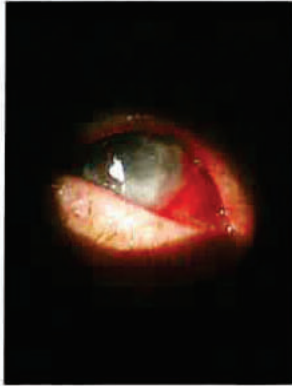
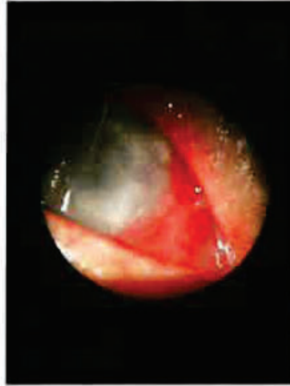
- Patient has appt for Retina and advised that best to cancel for now until OD improves - OD
Instructions: RTC Friday at office, make appointment with when patient returns.

## Staff:

, MD (Primary Provider) (Bill Under)

## Patient Referrals:

D OD - Referring Provider

| Other Photos | | |
|---|---|---|
|  od 1 |  od 2 | |

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 11/11/2024 05:17 PM PST

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 11/11/2024 05:17 PM PST

Visit Note - November 15, 2024

PRJS ID: Sex DOB MRN

## Medications
Reviewed November 8, 2024.

**OPHTHALMIC MEDICATIONS**

brimonidine 0.2% drops OD
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**

doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed November 8, 2024.
Cataract of right eye

### Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed November 8, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 8, 2024.
No known drug allergies

## Family History
Reviewed November 8, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed November 8, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed November 8, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. Central corneal ulceration OD F/U

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of Central corneal ulceration OD F/U. Patient reports OD feels a little better since last visit. Denies any pain or discomfort and reports using all medications as instructed.

   Using: : Moxifloxacin Q3HR OD
   Doxycycline 50mg BID PO
   Fortified Tobramycin 15mg/ ml every 1 hour around the clock when awake
   Fortified Vancomycin 25mg/ml every 3 hour around the clock when awake
   Dorzolamide BID OD
   Alphagan BID OD.

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | **HM** |
| | OS | **20/60**<br>**PH: 20/30 -2** |

### IOP
| | | | | |
|---|---|---|---|---|
| OD | 27 | MD | 11/15/2024 10:16 AM PST | Tonopen |
| OS | | MD | 11/15/2024 10:16 AM PST | Tonopen |

## Exam:
An examination was performed

| OD | OS |
|---|---|
| OD External: **NV on lid margin slight ectropion LL** | OS External: normal lid position, nasolacrimal and orbita exam |
| OD Lid Margin: quiet and normal | OS Lid Margin: quiet and normal |
| Slit lamp examination OD: | Slit lamp examination OS: |
| OD Conjunctiva: **3+ injection** | OS Conjunctiva: white and quiet |
| OD Cornea: **less dense infiltrate 7mmx4mm nasally -- ++ still associated epi defect over the infiltrate, 3+ PEE's** | OS Cornea: clear cornea |
| OD Anterior Chamber: **2mm hypopyon inferonasal --> resolved** | OS Anterior Chamber: deep and quiet anterior chamber |
| OD Iris: normal iris without rubeosis | OS Iris: normal iris without rubeosis |
| OD Lens: **PCIOL in place, open PC** | OS Lens: **PCIOL in place, open PC** |

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*

*- Corneal cultures taken of BCL and cornea by Dr. . Discussed case with*
*- Quest pick up conf# 177925934*
*-D/c Prednisolone and Ketorolac*
*See treatment plan for drops*

*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommnded inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommnded another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*

*11/4/2024. Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*

*11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*

*11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*

*11.11.24: slight improvement on todays exam. Patient to continue all drops as directed and return on Friday for follow up.*

*11/15/24: Slight continuous improvement. Spoke with and and adjusted drops for patient. Will follow up on Monday with*
(H16.011)

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy.
Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Start the following treatment(s): Start Combigan BID OD
Start Prednisolone BID .
Continue the following treatment(s): Doxycycline 50mg BID PO
Dorzolamide BID OD

Discontinue the following treatment(s): Alphagan BID OD.
Modify the following treatment(s): Moxifloxacin QID OD
Vancomycin QID OD
Tobramycin Q2H

Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be

determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
pending appt with Dr. [redacted]

## Follow Up

### 1. Follow Up for Next Visit

Instructions: Monday with [redacted] for follow up.

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted], D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 11/15/2024 10:43 AM PST

I, [redacted]r, MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted] MD, 11/15/2024 10:43 AM PST

Visit Note - November 18, 2024

PMS ID: DOB

## Medications
Reviewed and no changes noted November 18, 2024.

**OPHTHALMIC MEDICATIONS**
brimonidine 0.2% drops OD
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted November 18, 2024.
Cataract of right eye

## Ocular Surgery
History of left cataract extraction: 05.21.24 ( DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed November 18, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 18, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted November 18, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted November 18, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted November 18, 2024.

## Chief Complaints:
1. Central corneal ulcer OD

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of Central corneal ulcer OD. No pain vision not good. Using Moxilfoxacin qid, Vancomycin qid, Tobramycin q2h, Pred.1% BID, Combigan BID, Dorzolamide BID OD and doxycyline 50mg BID PO. Refresh 5-6 x OD and a few OS

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| Dsc | OD | **HM** |
|---|---|---|
| | OS | **20/50 +2**<br>**PH: 20/25 -1** |

### IOP

| | | | | |
|---|---|---|---|---|
| OD | 13 | MD | 11/18/2024 09:44 AM PST | Tonopen |
| OS | | MD | 11/18/2024 09:44 AM PST | Tonopen |

## Exam:
An examination was performed

OD External: **NV on lid margin slight ectropion LL**
OD Lid Margin: quiet and normal

OS External: normal lid position, nasolacrimal and orbita exam
OS Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **3+ injection**
OD Cornea: **less dense infiltrate 7mmx4mm nasally -- ++ still associated 5.5 x 2 mm epi defect over the infiltrate, 3+ PEE's**
OD Anterior Chamber: **2mm hypopyon inferonasal --> resolved**
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place, open PC**

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: clear cornea
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

PRELIMINARY

## Impression/Plan:
1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens, <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
*- Corneal cultures taken of BCL and cornea by Dr. Discussed case with .*
*- Quest pick up conf# 177925934*
*-D/c Prednisolone and Ketorolac*
*See treatment plan for drops*

*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*

*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommended inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommended another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*
*11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*
*11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*
*11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*
*11.11.24: slight improvement on todays exam. Patient to continue all drops as directed and return on Friday for follow up.*
*11/15/24: Slight continuous improvement. Spoke with [redacted] and [redacted] and adjusted drops for patient. Will follow up on Monday with [redacted]*
*11/18/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen.*
(H16.011)

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy. Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Continue the following treatment(s): Dorzolamide BID OD
Moxifloxacin QID OD
Prednisolone BID OD

Discontinue the following treatment(s): Vancomycin
Combigan.
Modify the following treatment(s): Decrease Tobramycin to 6x/day OD WA
Decrease Doxycycline 50mg PO to 1x/day

Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).
Other Instructions: Recommend waiting 1 hour after medicated eye drops before instilling ATs.

**Plan: Visit complexity.**
Medical care services associated with ongoing care, beyond the standard evaluation and management

Indication: Provided medical care services as part of ongoing care related to the patient's single, serious or complex chronic condition.

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted], given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of

PRELIMINARY

macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
followed by retina specialist

3. **Pseudophakia OU**
(Z96.1)

**Plan: Counseling - Pseudophakia.**
I counseled the patient regarding the following:
Pseudophakia: Stable, in good position

## Follow Up

1. **Follow Up for Next Visit**

Instructions: as scheduled on 11/22 with [redacted].

## Staff:

[redacted] MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted] D OD - Referring Provider

PRELIMINARY

# Visit Note - November 22, 2024

PMS ID: Sex: DOB MRN

## Medications
Reviewed and no changes noted November 22, 2024.

**OPHTHALMIC MEDICATIONS**
brimonidine 0.2% drops OD
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted November 22, 2024.
Cataract of right eye

## Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed November 22, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 22, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted November 22, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted November 22, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted November 22, 2024.

## Chief Complaints:
1. f/u due to corneal ulcer OD

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of f/u due to corneal ulcer OD. Pt denies having pain. Pt states everything is the same since last visit.

   Pt is using Dorzolamide BID OD, Moxifloxacin QID OD, Prednisolone BID OD, Tobramycin 6x/day OD WA, Doxycycline 50mg PO QD, Vitamin C 1,000mg, and AT's 4x/day OU.

## Eye Exam
### Vision
Distance Test Type: Snellen Chart    Near Test Type: Snellen

| Dcc | | |
|---|---|---|
| | OD | **HM** |
| | OS | **20/40 -2**<br>**PH: 20/30 -1** |

### IOP

| | | | | |
|---|---|---|---|---|
| OD | **Deferred** | | 11/22/2024 09:59 AM PST | Tonopen<br>Defer to MD |
| OS | | | 11/22/2024 09:59 AM PST | Tonopen |
| OD | **12** | | 11/22/2024 10:58 AM PST | Tonopen |
| OS | | | 11/22/2024 10:58 AM PST | Tonopen |

## Exam:
An examination was performed

OD External: **NV on lid margin slight ectropion LL**
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **3+ injection**
OD Cornea: **less dense infiltrate 7mmx4mm nasally -- ++ still associated 4 x 1 mm epi defect over the infiltrate, 3+ PEE's**
OD Anterior Chamber: **No hypopyon**
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place, open PC**

OS External: normal lid position, nasolacrimal and orbita exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: clear cornea
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
   *- Corneal cultures taken of BCL and cornea by Dr. Discussed case with*

, MD (Primary Provider) (Bill Under)

Total replacement of left knee joint

*- Quest pick up conf# 177925934*
*-D/c Ketorolac*
*See treatment plan for drops*

*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommended inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommended another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*
*11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*
*11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*
*11/08/24: less infiltrate on today's exam. slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*
*11.11.24: slight improvement on todays exam. Patient to continue all drops as directed and return on Friday for follow up.*
*11/15/24: Slight continuous improvement. Spoke with [redacted] and [redacted] and adjusted drops for patient. Will follow up on Monday with [redacted]*
*11/18/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen.*
*11/22/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen. Pt to be seen next WED.*
**(H16.011)**
Pain Intensity: 0.0 - No Pain

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy. Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Continue the following treatment(s): Dorzolamide BID OD
Moxifloxacin QID OD
Doxycycline 50mg PO 1x/day.
Discontinue the following treatment(s): Vancomycin and Combigan.
Modify the following treatment(s): Decrease Tobramycin to 5x/day OD WA
Increase Prednisolone TID OD

.
Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).
Other Instructions: Recommend waiting 1 hour after medicated eye drops before instilling ATs.

**Plan: Visit complexity.**
Medical care services associated with ongoing care, beyond the standard evaluation and management

Indication: Provided medical care services as part of ongoing care related to the patient's single, serious or complex chronic condition.

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted] given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
**(H35.81)**

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract

surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
followed by retina specialist

3. **Pseudophakia OU**
(Z96.1)

**Plan: Counseling - Pseudophakia.**
I counseled the patient regarding the following:
Pseudophakia: Stable, in good position

## Follow Up

1. **Follow Up for Next Visit**

Instructions: override appt on 11/27 with [redacted].

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted], D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 11/22/2024 11:02 AM PST

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 11/22/2024 11:02 AM PST

# Visit Note - November 27, 2024

PMS ID: Sex: DOB: MRN:

## Medications
Reviewed and changes noted November 27, 2024.

**OPHTHALMIC MEDICATIONS**
brimonidine 0.2% drops OD
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted November 27, 2024.
Cataract of right eye

### Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24 ( )
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed November 27, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 27, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted November 27, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted November 27, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed and no changes noted November 27, 2024.

## Chief Complaints:
1. Follow up cornea

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of Follow up cornea. Patient is here for follow up corneal ulcer OD. He is in no pain but frustrated that it is difficult to do things. Using OTC readers. He is currently using Dorzolamide BID OD, Moxifloxacin QID OD, Prednisolone TID OD, Tobramycin 6x/day OD WA, Doxycycline 50mg PO QD, Vitamin C 1,000mg, and AT's 4x/day OU.

## Eye Exam
### Vision
Distance Test Type: Snellen Chart    Distance Correction Type: None

| Dsc | OD | **HM**<br>**PH: NI** |
|---|---|---|
| | OS | **20/40 -1**<br>**PH: 20/30 +2** |

### IOP
| | | | | |
|---|---|---|---|---|
| OD | **Deferred** | | 11/27/2024 09:43 AM PST | Applanation MD to do |
| OS | | | 11/27/2024 09:43 AM PST | Applanation |
| OD | **17** | MD | 11/27/2024 10:44 AM PST | Tonopen |
| OS | | MD | 11/27/2024 10:44 AM PST | Tonopen |

### Exam:
An examination was performed

OD External: **NV on lid margin slight ectropion LL**
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **3+ injection**
OD Cornea: **less dense infiltrate 7mmx4mm nasally -- ++ still associated 1 x 2 mm very linear epi defect over the infiltrate (healing); 3+ PEE's**
OD Anterior Chamber: **No hypopyon**
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place, open PC**

OS External: normal lid position, nasolacrimal and orbita exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: clear cornea
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
*- Corneal cultures taken of BCL and cornea by Dr. . Discussed case with*

*- Quest pick up conf# 177925934*
*-D/c Ketorolac*
*See treatment plan for drops*

*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommended inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommended another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*
*11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*
*11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*
*11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*
*11.11.24: slight improvement on todays exam. Patient to continue all drops as directed and return on Friday for follow up.*
*11/15/24: Slight continuous improvement. Spoke with [redacted] and adjusted drops for patient. Will follow up on Monday with [redacted]*
*11/18/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen.*
*11/22/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen. Pt to be seen next WED.*
*11/27/24: Epi defect smaller and healing. IOP stable OD.*
(H16.011)

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy. Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Continue the following treatment(s): Dorzolamide BID OD
Moxifloxacin QID OD (erx'd with different sig so pt can get more refills)
Doxycycline 50mg PO 1x/day
Prednisolone TID OD.
Modify the following treatment(s): Decrease Tobramycin to 4x/day OD.
Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).
Other Instructions: Recommend waiting 1 hour after medicated eye drops before instilling ATs.

**Plan: Visit complexity.**
Medical care services associated with ongoing care, beyond the standard evaluation and management

Indication: Provided medical care services as part of ongoing care related to the patient's single, serious or complex chronic condition.

**Plan: Prescription.**
**moxifloxacin 0.5 % eye drops** Ophthalmic (eye)
Sig: instill 1 drop into the right eye once every 2 hours
**Quantity:** 9 Milliliter **Refills:** 3 **Earliest fill date:** November 27, 2024

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted], given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**

I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
followed by retina specialist

3. Pseudophakia OU
(Z96.1)

**Plan: Counseling - Pseudophakia.**
I counseled the patient regarding the following:
Pseudophakia: Stable, in good position

## Follow Up

1. Follow Up for Next Visit

Instructions: RTC for f/u with [redacted] in 1 week on Wednesday at [redacted].

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted], D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 11/27/2024 10:49 AM PST

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 11/27/2024 10:49 AM PST

# Visit Note - December 4, 2024

PMS ID: Sex: DOB: MRN:

## Medications
Reviewed November 27, 2024.

OPHTHALMIC MEDICATIONS
brimonidine 0.2% drops OD
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2% drops OD
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

NON OPHTHALMIC MEDICATIONS
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed November 27, 2024.
Cataract of right eye

## Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24 (
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed November 27, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed November 27, 2024.
No known drug allergies

## Family History
Reviewed November 27, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed November 27, 2024.
Arthritis
Diabetes mellitus: Pre-diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed November 27, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. follow up

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of follow up due to central corneal ulcer OD. The patient says it seems like vision OD is slightly improved. Denies pain. He is using ATs BID OD-sometimes OU, Dorzolamide BID OD, Moxifloxacin QID OD, Dozycycline 50mg PO QD, Prednisolone TID OD, Tobramycin QID OD, and 2 Vitamin C pills per day. H/o macular edema OD. S/P PCIOL OU.

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| Dsc | OD | **CF@1ft** |
|---|---|---|
| | OS | **20/40**<br>**PH: NI** |

### IOP

| | | | | |
|---|---|---|---|---|
| OD | **13** | | 12/04/2024 10:57 AM PST | Tonopen |
| OS | **12** | | 12/04/2024 10:57 AM PST | Tonopen |

### Diagnostic Drops

| | Drops Used | Staff | Date | Notes |
|---|---|---|---|---|
| OD | Proparacaine 0.5% | | 11:00 AM PST | |
| OS | Proparacaine 0.5% | | 11:00 AM PST | |

## Exam:
An examination was performed

OD External: **NV on lid margin**
**slight ectropion LL**
OD Lid Margin: quiet and normal

OS External: normal lid position, nasolacrimal and orbita exam
OS Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **1+ injection**
OD Cornea: **less dense infiltrate 7mmx4mm nasally -- ++ still associated 1 x 0.5 mm very linear epi defect over the infiltrate (healing); 3+ PEE's**
OD Anterior Chamber: **No hypopyon**
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place, open PC**

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: clear cornea
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:

1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
*- Corneal cultures taken of BCL and cornea by Dr. [redacted] Discussed case with [redacted]*
*- Quest pick up conf# 177925934*
*-D/c Ketorolac*
*See treatment plan for drops*

*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommended inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*

*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommended another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*
*11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*
*11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*
*11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*
*11.11.24: slight improvement on todays exam. Patient to continue all drops as directed and return on Friday for follow up.*
*11/15/24: Slight continuous improvement. Spoke with [redacted] and adjusted drops for patient. Will follow up on Monday with [redacted]*
*11/18/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen.*
*11/22/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen. Pt to be seen next WED.*
*11/27/24: Epi defect smaller and healing. IOP stable OD.*
*12/04/24: Epi defect getting smaller and healing. IOP stable OD.*
(H16.011)

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy.
Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Continue the following treatment(s): Dorzolamide BID OD
Doxycycline 50mg PO 1x/day
Prednisolone TID OD

.
Modify the following treatment(s): Decrease Moxifloxacin TID OD and Tobramycin 3x/day OD.
Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).
Other Instructions: Recommend waiting 1 hour after medicated eye drops before instilling ATs.

**Plan: Visit complexity.**
Medical care services associated with ongoing care, beyond the standard evaluation and management

Indication: Provided medical care services as part of ongoing care related to the patient's single, serious or complex chronic condition.

**Plan: Prescription.**
**moxifloxacin 0.5 % eye drops** Ophthalmic (eye)
Sig: instill 1 drop into the right eye once every 2 hours
**Quantity:** 9 Milliliter **Refills:** 3

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted] given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
followed by retina specialist

3. Pseudophakia OU
(Z96.1)

**Plan: Counseling - Pseudophakia.**
I counseled the patient regarding the following:
Pseudophakia: Stable, in good position

## Follow Up

1. Follow Up for Next Visit

Instructions: RTC for f/u with [redacted] next friday 12/13 at [redacted] **override**.

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted] D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 12/04/2024 11:41 AM PST

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 12/04/2024 11:41 AM PST

Visit Note - December 13, 2024

PMS ID: Sex DOB MRN

## Medications
Reviewed and changes noted December 13, 2024.

OPHTHALMIC MEDICATIONS
brimonidine 0.2 % eye drops 0.2% drops
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2 % eye drops 2% drops
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

NON OPHTHALMIC MEDICATIONS
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted December 13, 2024.
Cataract of right eye

## Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed December 13, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed December 13, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted December 13, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted December 13, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History

## Chief Complaints:
1. Follow up

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of Follow up. due to Central Corneal Ulceration OD. Patient has h/o Macular Edema OD. Patient states some visual improvement OD comparing to his last appointment.
Denies any ocular pain but states some discomfort due to decreased vision OD.
Denies other visual disturbance.
Patient is using Moxifloxacin, Tobramycin and Prednisolone TID OD and Dorzolamide BID OD.
Patient is also taking Doxy 1 a day and Vitamin C.

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | **CF@1ft**<br>**PH: NI** |
| | OS | **20/30 -2**<br>**PH: 20/25 +2** |

### Pupils: Normal

| | Light (mm) | Dark (mm) | Near (mm) | Size | Round | Regular | Reacts | APD | RAPD | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| OD | | | | Unspecified | Unspecified | Unspecified | Unspecified | | | |
| OS | | **3.00** | | Normal | Round | Regular | Reacts Well | No APD | | |

### IOP

| | | | | |
|---|---|---|---|---|
| OD | **12** | | 12/13/2024 09:19 AM PST | Tonopen |
| OS | **9** | | 12/13/2024 09:19 AM PST | Tonopen |

### Diagnostic Drops

| | Drops Used | Staff | Date | Notes |
|---|---|---|---|---|
| OD | Proparacaine 0.5% | | 09:22 AM PST | |
| OS | Proparacaine 0.5% | | 09:22 AM PST | |

## Exam:
An examination was performed

OD External: **NV on lid margin**
**slight ectropion LL**
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **1+ injection**
OD Cornea: **less dense infiltrate 7mmx4mm nasally--> becoming scar now;**
**NO epi defect; 3+ PEE's**
OD Anterior Chamber: **No hypopyon**
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place, open PC**

OS External: normal lid position, nasolacrimal and orbita exam

General Appearance of the patient is well nourished.

, MD (Primary Provider) (Bill Under)

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:

1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
*- Corneal cultures taken of BCL and cornea by Dr. [redacted] Discussed case with [redacted]*
*- Quest pick up conf# 177925934*
*-D/c Ketorolac*
*See treatment plan for drops*

*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommended inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow: discussed retina referral if continues to worsen to r/o posterior involvement*

*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommended another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*
*11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*
*11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*
*11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*
*11.11.24: slight improvement on todays exam. Patient to continue all drops as directed and return on Friday for follow up.*
*11/15/24: Slight continuous improvement. Spoke with [redacted] and adjusted drops for patient. Will follow up on Monday with [redacted]*
*11/18/24: Improving. smaller epi defect. IOP improved OD. See treatment regimen.*
*11/22/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen. Pt to be seen next WED.*
*11/27/24: Epi defect smaller and healing. IOP stable OD.*
*12/04/24: Epi defect getting smaller and healing. IOP stable OD.*
*12/13/24: NO epi defect, infiltrate becoming scar now. IOP stable OD.*
**(H16.011)**

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy. Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Continue the following treatment(s): Doxycycline 50mg PO 1x/day
Prednisolone TID OD.
Discontinue the following treatment(s): D/c dorzolamide for now, given IOP good, will re-check next visit.
Modify the following treatment(s): Decrease Moxifloxacin to BID OD and Tobramycin BID OD.
Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).
Other Instructions: Recommend waiting 1 hour after medicated eye drops before instilling ATs.

**Plan: Visit complexity.**
Medical care services associated with ongoing care, beyond the standard evaluation and management

Indication: Provided medical care services as part of ongoing care related to the patient's single, serious or complex chronic condition.

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted] given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
followed by retina specialist

3. **Pseudophakia OU**
(Z96.1)

**Plan: Counseling - Pseudophakia.**
I counseled the patient regarding the following:
Pseudophakia: Stable, in good position

## Follow Up

1. **Follow Up for Next Visit**

Instructions: RTC for f/u on 12/26 @ 12pm at [redacted] with [redacted]

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted]D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 12/13/2024 09:40 AM PST

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 12/13/2024 09:40 AM PST

## Medications
Reviewed and changes noted December 26, 2024.

OPHTHALMIC MEDICATIONS
brimonidine 0.2 % eye drops 0.2% drops
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2 % eye drops 2% drops
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

NON OPHTHALMIC MEDICATIONS
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted December 26, 2024.
Cataract of right eye

## Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed December 26, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed December 26, 2024.
No known drug allergies

## Family History
Reviewed and no changes noted December 26, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted December 26, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History

## Chief Complaints:
1. f/u

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of f/u. due to due to Central Corneal Ulceration OD. Patient has h/o Macular Edema OD. Patient states some visual improvement OD comparing to his last appointment. Denies any ocular pain but states some discomfort due to decreased vision OD. Denies other visual disturbance. Patient is using : Doxycycline 50mg PO 1x/day ,Prednisolone TID OD, Moxifloxacin to BID OD and Tobramycin BID OD, Vitamin C 1,000mg daily . Pt denies any other discomfort.

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| Dsc | OD | **CF@2ft**<br>**PH: NI** |
|---|---|---|
| | OS | **20/30**<br>**PH: 20/25** |

### IOP

| | | | |
|---|---|---|---|
| OD | **16** | 12/26/2024 12:07 PM PST | Applanation |
| OS | **13** | 12/26/2024 12:07 PM PST | Applanation |

## Exam:
An examination was performed

OD External: **NV on lid margin slight ectropion LL**
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **very tr injection**
OD Cornea: **diffuse scarring (prior 4x 7 mm infiltrate); NO epi defect; 3+ PEE's**
OD Anterior Chamber: **deep and qutie**
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place, open PC**

OS External: normal lid position, nasolacrimal and orbita exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: clear cornea
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema. and conjunctival injection present. Small epi defect present.*
*- Corneal cultures taken of BCL and cornea by Dr. Discussed case with*
*- Quest pick up conf# 177925934*
*-D/c Ketorolac*
*See treatment plan for drops*
*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*

Reviewed and no changes noted
December 26, 2024.
Total replacement of left knee joint

*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommended inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*
*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommended another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*
*11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*
*11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*
*11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*
*11.11.24: slight improvement on todays exam. Patient to continue all drops as directed and return on Friday for follow up.*
*11/15/24: Slight continuous improvement. Spoke with [REDACTED] and [REDACTED] and adjusted drops for patient. Will follow up on Monday with [REDACTED]*
*11/18/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen.*
*11/22/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen. Pt to be seen next WED.*
*11/27/24: Epi defect smaller and healing. IOP stable OD.*
*12/04/24: Epi defect getting smaller and healing. IOP stable OD.*
*12/13/24: NO epi defect, infiltrate becoming scar now. IOP stable OD.*
*12/26/24: Improving; resolved infiltrate with scar now; inflammation much improved*
(H16.011)

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy. Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Continue the following treatment(s): Doxycycline 50mg PO 1x/day
Prednisolone TID OD
Tobramycin BID OD.
Discontinue the following treatment(s): Moxifloxacin to BID .
Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).
Other Instructions: Recommend waiting 1 hour after medicated eye drops before instilling ATs.

**Plan: Visit complexity.**
Medical care services associated with ongoing care, beyond the standard evaluation and management

Indication: Provided medical care services as part of ongoing care related to the patient's single, serious or complex chronic condition.

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [REDACTED]; given corneal compromise, advised to discontinue medication until cornea recovers.*
*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision

may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
followed by retina specialist

3. **Pseudophakia OU**
(Z96.1)

**Plan: Counseling - Pseudophakia.**
I counseled the patient regarding the following:
Pseudophakia: Stable, in good position

## Follow Up

1. **Follow Up for Next Visit**

Instructions: RTC for f/u on 12/26 @ 12pm at [redacted] with [redacted]

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

## Patient Referrals:

[redacted] D OD - Referring Provider

Electronically Signed By: [redacted], MD, 12/26/2024 12:33 PM PST

# Visit Note - January 9, 2025

PMS ID: Sex: DOB: MRN:

## Medications
Reviewed December 26, 2024.

**OPHTHALMIC MEDICATIONS**
brimonidine 0.2 % eye drops 0.2% drops
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2 % eye drops 2% drops
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed December 26, 2024.
Cataract of right eye

### Ocular Surgery
History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed December 26, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed December 26, 2024.
No known drug allergies

## Family History
Reviewed December 26, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed December 26, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History
Reviewed December 26, 2024.
Total replacement of left knee joint

## Chief Complaints:
1. Corneal ulceration OD

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of Corneal ulceration OD. 2 week return for follow up. Pt states maybe some improvement in OD VA, no pain or discomfort OU, using ATs OU bid. Also using:

Pred OD tid
Tobramycin OD bid
Doxy 50 mg po qd
Vit C 1000 mg po qd

## Eye Exam

### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | **CF@2ft**<br>**PH: 20/400** |
| | OS | **20/40 +1**<br>**PH: 20/30** |

### Pupils: Normal

| | Light (mm) | Dark (mm) | Near (mm) | Size | Round | Regular | Reacts | APD | RAPD | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| OD | 3 | | | Normal | Round | Regular | Reacts Well | No APD | | |
| OS | 3 | | | Normal | Round | Regular | Reacts Well | No APD | | |

### IOP

| | | | | |
|---|---|---|---|---|
| OD | **Deferred** | | 01/09/2025 02:31 PM PST | Tonopen<br>Defer to doctor |
| OD | **14** | MD | 01/09/2025 02:49 PM PST | Tonopen |
| OS | | MD | 01/09/2025 02:49 PM PST | Tonopen |

**Motility: Full OU**

## Exam:
An examination was performed

OD External: **NV on lid margin**
**slight ectropion LL**
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **very tr injection**
OD Cornea: **diffuse scarring (prior 4x 7 mm infiltrate); NO epi defect; 3+ PEE's**
OD Anterior Chamber: **deep and qutie**
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place, open PC**

OS External: normal lid position, nasolacrimal and orbita exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: clear cornea
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:

1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
*- Corneal cultures taken of BCL and cornea by Dr. [redacted]. Discussed case with [redacted]*
*- Quest pick up conf# 177925934*
*-D/c Ketorolac*
*See treatment plan for drops*
*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommended inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*
*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommended another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*
*11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*
*11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*
*11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*
*11.11.24: slight improvement on todays exam. Patient to continue all drops as directed and return on Friday for follow up.*
*11/15/24: Slight continuous improvement. Spoke with [redacted] and adjusted drops for patient. Will follow up on Monday with [redacted]*
*11/18/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen.*
*11/22/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen. Pt to be seen next WED.*
*11/27/24: Epi defect smaller and healing. IOP stable OD.*
*12/04/24: Epi defect getting smaller and healing. IOP stable OD.*
*12/13/24: NO epi defect, infiltrate becoming scar now. IOP stable OD.*
*12/26/24: Improving; resolved infiltrate with scar now; inflammation much improved*
*01/09/25: Improved, resolved infiltrate with scar now; inflammation much improved, IOP stable.*
(H16.011)

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office If: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy.
Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Continue the following treatment(s): Doxycycline 50mg PO 1x/day
Prednisolone TID OD
.
Discontinue the following treatment(s): Tobramycin BID OD.
Recommend the following Over-The-Counter treatment(s): continue Vitamin C 1,000mg (OTC).
Other Instructions: Recommend waiting 1 hour after medicated eye drops before instilling ATs.

**Plan: Visit complexity.**
Medical care services associated with ongoing care, beyond the standard evaluation and management

Indication: Provided medical care services as part of ongoing care related to the patient's single, serious or complex chronic condition.

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted] given corneal compromise, advised to discontinue medication until cornea recovers.*

*will hold off on using Ketorolac and prednisolone gtt at this time.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
followed by retina specialist

3. **Pseudophakia OU**
(Z96.1)

**Plan: Counseling - Pseudophakia.**
I counseled the patient regarding the following:
Pseudophakia: Stable, in good position

## Follow Up

1. **Follow Up for Next Visit**

Instructions: RTC for f/u on 2-3 weeks follow up at [redacted] with [redacted].

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted] D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 01/09/2025 04:35 PM PST

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 01/09/2025 04:35 PM PST

# Visit Note - January 24, 2025

PMS ID: Sex: DOB MRN:

## Medications

Reviewed December 26, 2024.

OPHTHALMIC MEDICATIONS

brimonidine 0.2 % eye drops 0.2% drops
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2 % eye drops 2% drops
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

NON OPHTHALMIC MEDICATIONS

doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History

Reviewed December 26, 2024.
Cataract of right eye

### Ocular Surgery

History of left cataract extraction: 05.21.24 ( ) DISTANCE
History of right cataract extraction: 06.11.24 ( ) DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History

Reviewed December 26, 2024.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies

Reviewed December 26, 2024.
No known drug allergies

## Family History

Reviewed December 26, 2024.
Family history of diabetes mellitus type 2 (situation)

## Medical History

Reviewed December 26, 2024.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History

Reviewed December 26, 2024.
Total replacement of left knee joint

## Chief Complaints:

1. 2 week follow up secondary to Central Corneal Ulceration OD.

## HPI: This is an 85 year old male who:

1. is being seen for a chief complaint of 2 week follow up secondary to Central Corneal Ulceration OD. Pt reports noticing slight improvement with va, OD. Pt c/o noticing depth perception is worse. Pt is compliant with Doxycycline and Pred. Pt denies any pain or discomfort, OU.

   H/O Macular Edema OD. H/O Pseudophakia OU.

   Doxycycline 50mg QD PO
   Prednisolone TID OD
   Vitamin C 1000mg QD
   Refresh TID OU

## Eye Exam

### Vision

Distance Test Type: Snellen Chart

| Dsc | OD | **CF@4ft** |
|---|---|---|
| | OS | **20/30 -2** |

### IOP

| | | | |
|---|---|---|---|
| OD | 12 | 01/24/2025 01:54 PM PST | Tonopen |
| OS | 15 | 01/24/2025 01:54 PM PST | Tonopen |

## Exam:

An examination was performed

OD External: **NV on lid margin slight ectropion LL**
OD Lid Margin: quiet and normal

OS External: normal lid position, nasolacrimal and orbita exam
OS Lid Margin: quiet and normal

Slit lamp examination OD:

OD Conjunctiva: **very tr injection**

OD Cornea: **diffuse scarring (prior 4x 7 mm infiltrate); NO epi defect; 3+ PEE's**

OD Anterior Chamber: **deep and qutie**

OD Iris: normal iris without rubeosis

OD Lens: **PCIOL in place, open PC**

Slit lamp examination OS:

OS Conjunctiva: white and quiet

OS Cornea: clear cornea

OS Anterior Chamber: deep and quiet anterior chamber

OS Iris: normal iris without rubeosis

OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:

1. **Central Corneal Ulceration OD** - *10/30/2024: Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
   *- Corneal cultures taken of BCL and cornea by Dr. . Discussed case with*
   *- Quest pick up conf# 177925934*
   *-D/c Ketorolac*

*See treatment plan for drops*
*10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
*Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
*Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
*recommended inject sub-conj 50 mcg/ml of Cefazolin -- done*
*Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
*Will follow up tomorrow: discussed retina referral if continues to worsen to r/o posterior involvement*
*11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
*Stable today from yesterday -- hypopyon slightly better and fibrin resolving.*
*Recommended another inject sub-conj 50 mg/ml of Cefazolin -- done today*
*Slit lamp photos taken today*
*11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*
*11/06/24: Slight improvement in hypopyon, less infiltrate on today's exam. Slit lamp photos taken. Cont. drop regimen*
*11/08/24: less infiltrate on today's exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*
*11.11.24: slight improvement on todays exam. Patient to continue all drops as directed and return on Friday for follow up.*
*11/15/24: Slight continuous improvement. Spoke with [redacted] and adjusted drops for patient. Will follow up on Monday with [redacted]*
*11/18/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen.*
*11/22/24: Improving, smaller epi defect. IOP improved OD. See treatment regimen. Pt to be seen next WED.*
*11/27/24: Epi defect smaller and healing. IOP stable OD.*
*12/04/24: Epi defect getting smaller and healing. IOP stable OD.*
*12/13/24: NO epi defect, infiltrate becoming scar now. IOP stable OD.*
*12/26/24: Improving; resolved infiltrate with scar now; inflammation much improved*
*01/09/25: Improved, resolved infiltrate with scar now; inflammation much improved, IOP stable.*
*01/24/25: Over stable. No infiltrates. Will continue current regimen. Will see if scar reduces or fades over next few weeks, will consider corneal transplant vs Hard Cls in future.*
(H16.011)

**Plan: Counseling - Corneal Ulcer.**
I counseled the patient regarding the following:
Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy.
Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

Medical Decision Making - OD
treatment regimen

**Plan: Treatment Regimen.**
Continue the following treatment(s): Doxycycline 50mg PO 1x/day

Modify the following treatment(s): Decrease Prednisolone BID OD.
Recommend the following Over-The-Counter treatment(s): continue Vitamin C 1,000mg (OTC).
Other Instructions: Recommend waiting 1 hour after medicated eye drops before instilling ATs.

**Plan: Visit complexity.**
Medical care services associated with ongoing care, beyond the standard evaluation and management

Indication: Provided medical care services as part of ongoing care related to the patient's single, serious or complex chronic condition.

**Plan: Prescription.**
**prednisolone acetate 1 % eye drops,suspension** Ophthalmic (eye)
**Location:** OD
**Sig:** Instill 1 drop into the right eye twice daily
**Quantity:** 10 Milliliter **Refills:** 5 **Earliest fill date:** January 24, 2025

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted] given corneal compromise, will monitor until cornea recovers.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the

underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
followed by retina specialist

3. **Pseudophakia OU**
(Z96.1)

**Plan: Counseling - Pseudophakia.**
I counseled the patient regarding the following:
Pseudophakia: Stable, in good position

## Follow Up

1. **Follow Up for Next Visit**

Instructions: RTC for f/u in 1 month with [redacted]

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted], D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 01/24/2025 03:02 PM PST

I, [redacted], MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 01/24/2025 03:02 PM PST

Visit Note - February 14, 2025

PMS ID: Sex: DOB MRN

## Medications
Reviewed and changes noted February 14, 2025.

**OPHTHALMIC MEDICATIONS**
brimonidine 0.2 % eye drops 0.2% drops
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2 % eye drops 2% drops
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted February 14, 2025.
Cataract of right eye

### Ocular Surgery
History of left cataract extraction: 05.21.24 DISTANCE
History of right cataract extraction: 06.11.24 DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24 )
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed February 14, 2025.
Smoking status - Former smoker
Pneumonia vaccination administered or previously received

## Allergies
Reviewed February 14, 2025.
No known drug allergies

## Family History
Reviewed and no changes noted February 14, 2025.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted February 14, 2025.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History

## Chief Complaints:
1. x1mo. Follow up to K-Ulcer OD

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of x1mo. Follow up to K-Ulcer OD. Pt. states, overall vision still blurred but stable for distance.
   Pt. Denies any pressure, tension or pain. OU.
   Pt. continues the Doxycycline 50mg qd.PO. / Prednisolone BID OD./ Refresh Tears TID OU, and Vitamin C 1000mg. (OTC).

## Eye Exam

### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | **20/400 PH: 20/200** |
| | OS | **20/40 PH: 20/30** |

### Pupils: Normal

| | Light (mm) | Dark (mm) | Near (mm) | Size | Round | Regular | Reacts | APD | RAPD | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| OD | **2.5** | | | Normal | Round | Regular | Reacts Well | No APD | | |
| OS | **2.5** | | | Normal | Round | Regular | Reacts Well | No APD | | |

### IOP

| | | | | |
|---|---|---|---|---|
| OD | **12** | | 02/14/2025 10:01 AM PST | Tonopen |
| OS | **13** | | 02/14/2025 10:01 AM PST | Tonopen |

### Diagnostic Drops

| | Drops Used | Staff | Date | Notes |
|---|---|---|---|---|
| OD | Proparacaine 0.5% | | 10:02 AM PST | |
| OS | Proparacaine 0.5% | | 10:02 AM PST | |

## Exam:
An examination was performed

OD External: **dermatochalasis NV on lid margin slight ectropion LL**
OD Lid Margin: quiet and normal

OS External: **dermatochalasis**
OS Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **very tr injection**
OD Cornea: **diffuse scarring (prior 4x 7 mm infiltrate); NO epi defect; 3+ PEE's**
OD Anterior Chamber: **deep and qutie**
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place, open PC**

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: clear cornea
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: **PCIOL in place, open PC**

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

, MD (Primary Provider) (Bill Under)

Reviewed and no changes noted
February 14, 2025.
Total replacement of left knee joint

Mood and affect: no acute distress.

## Impression/Plan:

1. **Central Corneal Ulceration OD** - *Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
   *- Corneal cultures taken of BCL and cornea by Dr. [redacted] Discussed case with [redacted]*

   *10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
   *Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
   *Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
   *recommended inject sub-conj 50 mcg/ml of Cefazolin -- done*
   *Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
   *Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*
   *11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
   *Stable from yesterday -- hypopyon slightly better and fibrin resolving.*
   *Recommended another inject sub-conj 50 mg/ml of Cefazolin -- done*
   *11/4/2024: Labs received and confirmed ++ Pseudomonas Aeruginosa. Stable from visit 11/1/24. Slit lamp photos taken today*
   *11/06/24: Slight improvement in hypopyon, less infiltrate on exam. Cont. drop regimen*
   *11/08/24: less infiltrate on exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*

   *11/11/24 - 11/15/2024: slight improvement on exam.*
   *11/18/24 - 12/04/2024: Improving, smaller epi defect. IOP improved OD. See treatment regimen.*
   *12/13/24 - 1/09/2025: NO epi defect, infiltrate becoming scar now. IOP stable OD.*
   *01/24/25: Over stable. No infiltrates. Will continue current regimen. Will see if scar reduces or fades over next few weeks, will consider corneal transplant vs Hard Cls in future.*

   *2/14/2025: Stable exam. No infiltrate. Continue adjusted regimen.*
   **(H16.011)**
   Pain Intensity: 1.0 - 1/10 Pain

   **Plan: Counseling - Corneal Ulcer.**
   I counseled the patient regarding the following:
   Discussed the severity of corneal ulcer infection and that it will require frequent antibiotic drop administration and possible other means of treatment to try to treat the severe infection of the cornea
   ------------------
   Expectations: Corneal ulcers are serious infections of the eye that have extended beneath the ocular surface. It may result in scarring, loss of vision, perforation of the eye ball, or even loss of the eye.
   ------------------
   Contact Office if: Because of the serious nature of this condition, corneal ulcer patients usually need to be seen frequently, and treated with special fortified antibiotic eye drops that are not available at your local pharmacy.
   ------------------
   Corneal scrapings for identification of the type of infecting organism may be helpful in both making the correct diagnosis and guiding the selection of antibiotic therapy.

   Medical Decision Making - OD
   treatment regimen

   **Plan: Treatment Regimen.**
   Continue the following treatment(s): Prednisolone BID OD.
   Discontinue the following treatment(s): STOP Doxycycline 50mg PO 1x/day.
   Recommend the following Over-The-Counter treatment(s): continue Vitamin C 1,000mg (OTC).
   Other Instructions: Recommend waiting 1 hour after medicated eye drops before instilling ATs.

   **Plan: Visit complexity.**
   Medical care services associated with ongoing care, beyond the standard evaluation and management

   Indication: Provided medical care services as part of ongoing care related to the patient's single, serious or complex chronic condition.

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. [redacted], given corneal compromise, will monitor until cornea recovers.*
   **(H35.81)**

   **Plan: Counseling - Macular Edema.**

I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
followed by retina specialist

3. **Pseudophakia OU**
(Z96.1)

**Plan: Counseling - Pseudophakia.**
I counseled the patient regarding the following:
Pseudophakia: Stable, in good position

## Follow Up

1. **Follow Up for Next Visit**

Instructions: RTC in 1 mos f/u with [redacted] with TOPO and Anterior Segment OCT OD.

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]

[redacted] (scribe)

## Patient Referrals:

[redacted], D OD - Referring Provider

I, [redacted] am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], 02/14/2025 10:54 AM PST

I, [redacted] MD, personally performed the services described in the documentation as scribed by [redacted] in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [redacted], MD, 02/14/2025 10:54 AM PST

## Medications
Reviewed and no changes noted March 14, 2025.

**OPHTHALMIC MEDICATIONS**
brimonidine 0.2 % eye drops 0.2% drops
cyclopentolate 0.5% drops OD
cyclopentolate 1% drops OD
dorzolamide 2 % eye drops 2% drops
ketorolac 0.5% drops
ketorolac 0.5% drops OD
moxifloxacin 0.5% drops
moxifloxacin 0.5% drops OD
moxifloxacin 0.5% drops
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% drops, suspension OD
tobramycin 0.3% drops

**NON OPHTHALMIC MEDICATIONS**
doxycycline monohydrate 50 mg Oral - tablet
dutasteride 0.5 mg Oral - capsule
Eliquis 2.5 mg Oral - tablet
losartan 25 mg Oral - tablet
tamsulosin 0.4 mg Oral - capsule

## Ocular History
Reviewed and no changes noted March 14, 2025.
Cataract of right eye

## Ocular Surgery
History of left cataract extraction: 05.21.24 DISTANCE
History of right cataract extraction: 06.11.24 DISTANCE
YAG laser capsulotomy of lens - Right eye structure: 10/15/24
YAG laser capsulotomy of lens - Left eye structure: 10/22/2024 -

## Social History
Reviewed March 14, 2025.
Smoking status - Former smoker

Pneumonia vaccination administered or previously received

## Allergies
Reviewed March 14, 2025.
No known drug allergies

## Family History
Reviewed and no changes noted March 14, 2025.
Family history of diabetes mellitus type 2 (situation)

## Medical History
Reviewed and no changes noted March 14, 2025.
Arthritis
Diabetes mellitus: Pre- diabetic
H/O: hypertension
Other: Rashes, enlarged prostate, blood clots left leg

## Surgical History

## Chief Complaints:
1. follow up

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of follow up due to Central corneal ulcer OD and macular edema OD. The patient says vision in the right eye seems to be improving. Stable vision in the left eye. Denies pain. He is using Prednisolone BID OD and Refresh TID OU. Taking Vitamin C BID PO. S/P PCIOL OU.

   Patient would like to know if he should keep appointment with retina in April.

## Historical Summary:
Pachy 03.14.25:
OD 358 (OCT)

## Eye Exam
### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | **CF@2ft**<br>**PH: 20/80 -2** |
| | OS | **20/40 -2**<br>**PH: NI** |

### IOP
| | | | | |
|---|---|---|---|---|
| OD | 13 | | 03/14/2025 10:23 AM PDT | Tonopen |
| OS | 13 | | 03/14/2025 10:23 AM PDT | Tonopen |

### Diagnostic Drops
| | Drops Used | Staff | Date | Notes |
|---|---|---|---|---|
| OD | Proparacaine 0.5% | | 10:23 AM PDT | |
| OS | Proparacaine 0.5% | | 10:23 AM PDT | |

### Pachymetry
| | Central Cornea | Superior Cornea | Nasal Cornea | Inferior Cornea | Temporal Cornea |
|---|---|---|---|---|---|
| OD | 358.0 | | | | |

## Exam:
An examination was performed

OD External: **dermatochalasis NV on lid margin slight ectropion LL**
OD Lid Margin: quiet and normal

OS External: **dermatochalasis**
OS Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: **very tr injection**
OD Cornea: **diffuse scarring (prior 4 x 7 mm infiltrate); NO epi defect; 3+ PEE's**
OD Anterior Chamber: **deep and qutie**
OD Iris: normal iris without rubeosis
OD Lens: **PCIOL in place, open PC**

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: **few PEEs**
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: **PCIOL in place, open PC**

Reviewed and no changes noted
March 14, 2025.
Total replacement of left knee joint

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Tests

### Corneal Topography

A same-day order was placed for this diagnostic test.

Diagnostic Procedure: Corneal Topography - OU
Indication: Corneal Scarring OD

Corneal Topography Result OD: astigmatism, irregular

Corneal Topography Result OS: astigmatism, regular
Reliability: good

Assessment OD: stable compared to previous study
Assessment OS: stable compared to previous study

### Corneal Pachymetry

A same-day order was placed for this diagnostic test.

Diagnostic Procedure: Corneal Pachymetry - OD
Method Used: ultrasound
Indication: Corneal Scarring OD

Central Corneal Thickness OD: thin
Central Corneal Thickness OD: 358 microns

Reliability: good
Assessment OD: stable compared to previous study

## Impression/Plan:

1. **Corneal Scarring OD** - *H/o of severe Corneal ulcer OD - likely secondary to retained bandage contact lens. <1 mm hypopyon, corneal edema, and conjunctival injection present. Small epi defect present.*
   *- Corneal cultures taken of BCL and cornea by Dr. [redacted]. Discussed case with [redacted]*

   *10/31/2024: Also h/o of hospitalization once months ago with blood sepsis.*
   *Worsening with large infiltrate nasally 10 x 6 mm; 2 mm hypopyon and some fibrin.*
   *Given worsening most likely Pseudomonas A. . Labs still pending and follow up tomorrow.*
   *recommended inject sub-conj 50 mcg/ml of Cefazolin -- done*
   *Will add Tobramycin until gets fortified Tobra and Vanco (will be delivered tomorrow)*
   *Will follow up tomorrow; discussed retina referral if continues to worsen to r/o posterior involvement*
   *11/1/2024: Labs: ++ Gram negative bacilli -- most likely Pseudomonas A. Final ID pending -- can adjust Vanco when final ID back*
   *Stable from yesterday -- hypopyon slightly better and fibrin resolving.*
   *Recommended another inject sub-conj 50 mg/ml of Cefazolin -- done*
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   *11/06/24: Slight improvement in hypopyon, less infiltrate on exam. Cont. drop regimen*
   *11/08/24: less infiltrate on exam, slight improvement in hypopyon. Elevated IOP today (30 OD). Recommend increase in AT's and cont. drop regimen. Will start on Brimonidine BID OD -- erx'd (Alphagan sample given in office) and Dorzolamide BID OD.*
   *11/11/24 - 11/15/2024: slight improvement on exam.*
   *11/18/24 - 12/04/2024: Improving, smaller epi defect. IOP improved OD. See treatment regimen.*
   *12/13/24 - 1/09/2025: NO epi defect, infiltrate becoming scar now. IOP stable OD.*
   *01/24/25: Over stable. No infiltrates. Will continue current regimen. Will see if scar reduces or fades over next few*

*weeks, will consider corneal transplant vs Hard Cls in future.*
*2/14/2025: Stable exam. No infiltrate. Continue adjusted regimen.*
*03/14/2025: Stable, no infiltrates. Diffuse scarring slightly fading. Patient hesitant on PKP OD, discussed can be fitted with Scleral lens or RGP, even if unable to tolerate can see what BCVA is OD. Pt has second opinion with Dr.*
(H17.89)

**Plan: Treatment Regimen.**
Continue the following treatment(s): Prednisolone BID OD.
Recommend the following Over-The-Counter treatment(s): Vitamin C 1,000mg (OTC).
Other Instructions: Recommend waiting 1 hour after medicated eye drops before instilling ATs.

2. **Macular Edema OD** - *macular edema OU - previously noted by Dr. given corneal compromise, will monitor until cornea recovers.*
(H35.81)

**Plan: Counseling - Macular Edema.**
I counseled the patient regarding the following:
Eye care: Macular edema is treated with multiple different modalities. There are many different causes of macular edema. Common causes included diabetes, wet macular degeneration, uveitis and post cataract surgery. If this is a consequence of systemic diabetes a large part of the treatment for diabetic macular edema is control of systemic diabetes with control of blood sugars. Treatment will be directed based on the underlying etiology. Treatment modalities may include eye drops, laser procedures, intravitreal injections and vitrectomy with membrane peel.
Expectations: Macular edema is a disease that may be caused multiple different factors. Initially, the cause of macular edema must be determined. The goal of treatment for the macular edema is to have resolution of edema to decrease risk of further loss of vision and blindness. If there is not permanent irreversible damage the vision may improve. It is important to understand that macular edema may be recurrent and multiple treatments may be necessary of a long period of time.
Contact Office If: You experience decrease in vision, pain, redness, flashes/floaters, black shadow or curtain or other eye concerns you may have.

Medical Decision Making - OD
followed by retina specialist

3. **Pseudophakia OU**
(Z96.1)

**Plan: Counseling - Pseudophakia.**
I counseled the patient regarding the following:
Pseudophakia: Stable, in good position

## Follow Up

1. **Follow Up for Next Visit**

Instructions: RTC in 6 weeks for follow up with

## Staff:

, MD (Primary Provider) (Bill Under)

(scribe)

## Patient Referrals:

, D OD - Referring Provider

I, am scribing for, and in the presence of , MD.

Electronically Signed By: , 03/14/2025 10:59 AM PDT

I, . MD, personally performed the services described in the documentation as scribed by in my presence, and confirm it is both accurate and complete.

Electronically Signed By: , MD, 03/14/2025 10:59 AM PDT

**PROCEDURE DATE** 06/11/24

**SURGEON:**

84 yrs. M

**PATIENT NAME:**

**ANESTHESIA:** Monitored Anesthesia Care

**PREOPERATIVE DIAGNOSIS:** Cataract, RIGHT / LEFT eye

**POSTOPERATIVE DIAGNOSIS:** Same as preoperative diagnosis

**PROCEDURE:** Phacoemulsification of Cataract and Insertion of Intraocular Lens, RIGHT / LEFT eye

SN: 3Q06647157
Use By 2027-02-28
BAUSCH & LOMB
ØT: 12.5 mm
MX60E +17.00D
ØB: 6.00 mm

**PROCEDURE IN DETAIL:**

The patient was brought to operating room. Under intravenous sedation and topical anesthetic the operative eye was prepped and draped in the usual sterile ophthalmic fashion. A wire lid speculum was placed in the eye. A clear corneal incision was made with a 2.7 mm keratome and a secondary stab incision was made to the left. The anterior chamber was filled with viscoelastic and a continuous tear capsulotomy was made.

After hydrodissection, the nucleus was removed with phacoemulsification. The remaining cortex was removed with I&A and capsule polisher. The eye was filled with viscoelastic. The intraocular lens was inserted and centered in the capsular bag.

The viscoelastic was exchanged for balanced salt solution and the anterior chamber was pressurized. No sutures were required. The intraocular lens was verified to be in good position and the wound was verified to be watertight. The speculum was removed from the eye. The patient was awakened and taken to the recovery room in good condition.

, M.D.

 10/31/2024 11:08:37 PM **Report Status: Partial - Courtesy Copy**

| Patient Information | Specimen Information | Client Information |
|---|---|---|
| **DOB:** **AGE: 84**<br>Gender: M Fasting: U<br>Phone:<br>Patient ID: | Specimen:<br>Requisition:<br><br>Collected: 10/30/2024<br>Received: 10/30/2024 / 20:57 PDT<br>Faxed: 10/31/2024 / 23:05 PDT | Client #: MAIL500 |

| Test Name | In Range | Out Of Range | Reference Range | Lab |
|---|---|---|---|---|

================================

QAW

CULTURE, ANAEROBIC BACTERIA W/GRAM STAIN

```
Micro Number:        22990005
Test Status:         Preliminary
Specimen Source:     Rt eye cornea
Specimen Quality:    Adequate
Gram Stain:          Rare epithelial cells
                     Few White blood cells seen
                     Few Gram negative bacilli
```

================================

QAW

CULTURE, AEROBIC BACTERIA

```
Micro Number:        22990006
Test Status:         Preliminary
Specimen Source:     Rt eye cornea
Specimen Quality:    Adequate
Result:              Heavy growth of Gram negative bacilli isolated
                     Identification and susceptibilities to follow.
```

================================

QAW

CULTURE, FUNGUS W/SMEAR NOT HAIR, SKIN, BLOOD

```
Micro Number:        22990007
Test Status:         Preliminary
Specimen Source:     Rt eye cornea
Specimen Quality:    Adequate
Smear:               No fungal elements seen.
```

**PERFORMING SITE:**

QAW QUEST DIAGNOSTICS LAS VEGAS, 4230 BURNHAM AVENUE, LAS VEGAS, NV 89119-5408 Laboratory Director: CHRISTINE RUEMMLER-GAMBLE,MD, CLIA: 29D0652720

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**Report Status: Partial - Courtesy Copy**

| Patient Information | Specimen Information | Client Information |
|---|---|---|
| DOB: AGE: 84<br>Gender: M Fasting: U<br>Patient ID: | Specimen:<br>Collected: 10/30/2024<br>Received: 10/30/2024 / 20:57 PDT<br>Faxed: 10/31/2024 / 23:05 PDT | Client #: |

| Test Name | In Range | Out Of Range | Reference Range | Lab |
|---|---|---|---|---|
| TEST IN QUESTION-AMBIGUOUS ORDER | | | | QAW |

QUESTION/PROBLEM:

We are unable to ascertain the test(s) you desire for the irreplaceable specimen you submitted.

UNCLEAR ORDER: VERIFY THE SOURCE

SPECIMEN(S) SUBMITTED:

3 MICRO PLATE

Requested Information:______________________________

Authorized Signature:______________________________

To prevent further delays in testing, please complete information above and fax to 702-425-9897 or email to lvtiqfaxes@questdiagnostics.com to resolve this order.

**PERFORMING SITE:**

QAW QUEST DIAGNOSTICS LAS VEGAS 4230 BURNHAM AVENUE LAS VEGAS NV 89119-5408 MEDICAL DIRECTOR: CHRISTINE RUEMMLER-GAMBLE,MD CLIA NO: 29D0652720



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Femto Time Out: ______ □n/a
OR Time Out: 1042
OR#: 1

Patient Allergies: NKA

✓ Patient ID Verified: ☑ Armband ☑ Verbal
✓ Surgical Site Verified: ☑ Patient ☑ Consent ☑ Chart ☐ H&P or chart

☑ Surgical Safety Checklist Utilized

Surgery Start Time: 1053
Surgery End Time: n/a
Surgery Tech: Carter
Others Present: ______

Surgeon: ______
Anesthesiologist: ______
Circulator: ______
Femto Operator: ______

Procedure: ☑ Cataract Extraction with Implant of Intraocular Lens Right eye □ LRI □ ORA □ Femto
□ ______

Anesthesia Type: ☑ MAC □ Local □ Block □ Topical □ General
Case Class: ☑ Clean □ Contaminated □ Dirty

Prep: ☑ Betadine 10% to surgical site ☑ Ophthalmic Iodine 5% instilled in eye □ PCMX □ Other: ______

Position: ☑ Supine Supportive Device(s): ☑ Pillow, knees ☑ Side Rails 1 x2 ☑ Safety Strap □ Head Taped □ Site(s) inspected and skin intact

Equipment: ☑ Phaco □ Microscope □ Bipolar □ ESU Ground Pad Placement ______ □ Site inspected skin intact after use

**Intraoperative Medications/Supplies:**

*Anesthetic qtts:* ☑ Proparacaine
*Viscoelastic:* □ Healon GV ☑ Healon □ Provisc □ Duovisc □ Amvisc □ Anikavisc
*Intermittent intraocular irrigation:* ☑ 500ml BSS □ BSS 15ml
*Ophthalmic Medication:* □ Bacitracin □ Maxitrol □ Vigamox □ Erythromycin
□ Vigamox □ Timolol □ Atropine 1% ☑ Ciprofloxacin ☑ Prednisolone 1%
□ Phenylephrine 2.5% □ Ofloxacin □ 1% Pilocarpine
□ 100% Ethanol Alcohol 1:1 w/ BSS □ EDTA 3.75%
□ Trypan Blue □ Miochol-E / Miostat
□ Xylocaine 2% □ Xylocaine MPF % □ Lidocaine 1% w/ Phenylephrine 1.5% Lot # ______ Exp Date: ______
□ Mitomycin - Lot #: ______ Exp Date ______ □ 0.75% Marcaine
□ Vancomycin 50mg/ml ___ ml
□ Kenalog 40mg □ Ancef 50mg/Decadron 4mg
□ Other: □ Moxifloxacin □ Bupivacaine 0.50% / 0.75%

□ Malyugin Ring
□ Iris Retractor
☑ Eye Shield
☑ Bandage Contact Lens
□ Suture: ______
□ EBL:

□ Vitrectomy
□ Sheet Glide
□ Eye Pad
□ Tisseel Glue

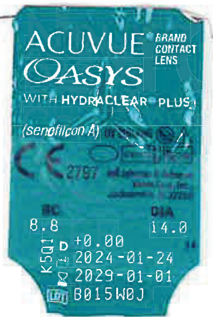
Pathology Source ______ □ To lab ☑ Discarded Culture Source ______ □ To lab

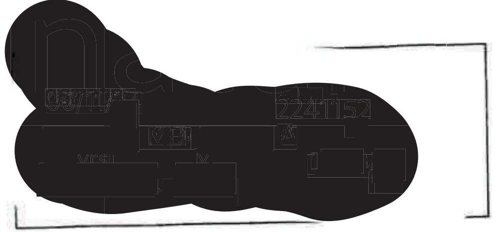
Comments:

Patient transferred to PACU ...
Report given to RN: ______

R.N. Signature

SN: 3Q00047... BAUSCH & LOMB 2017-07-28



Surgery Center

## Postoperative Record

Arrival Time to PACU: 1103 ☒ Gurney ☐ W/C ☐ Other ______ Report given by [illegible]

Airway: ☒ N/A ☐ Oral ☐ Nasal Airway D/C'd @______

O2: ☒ N/A ☐ Nasal Cannula ☐ Mask @ Liter/Min ____ D/C'd @____ ☐ IV Solution ______ Amount Infused in PACU: ______

**ALLERGIES**: NKA

| Pre- Op VS | 148/97 | 97.5 | 64 | 20 | 96% | Ø | Ø |
|---|---|---|---|---|---|---|---|

**Pre-op Blood Glucose**________ Normal range 70-100

| Post-Op VS | BP | T | P | R | $SAO_2$ O/O | Pain Level | N/V |
|---|---|---|---|---|---|---|---|
| 1104 | 105/62 | 97.0 | 60 | 16 | 94 | 0/10 | Ø |
| 1109 | 103/67 | | 60 | 16 | 95 | 0/10 | Ø |
| 1114 | 110/64 | | 66 | 16 | 95 | 0/10 | Ø |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| Criteria PACU Score | Arrival | Discharge |
|---|---|---|
| LOC: 2- Awake, Alert, Oriented; 1- Drowsy, Awakens Easily; 0- Not Responding | 1 | 2 |
| Color: 2- Pink, warm & Dry; 1- Pale, dusky, Cool & Moist; 0- Cyanotic | 2 | 2 |
| V.S.: 2- BP ± 20% Pre-op; 1- BP ± 20% - 50% Pre-op; 0- BP 50% Pre-op | 2 | 2 |
| Resp: 2- Able to DB & Cough; 1- Dyspnea/Difficulty Breathing; 0- Apnea | 2 | 2 |
| Activity: 2- Able to Ambulate; 1- Weak, needs Assistance; 0- Unable to Move Self | 1 | 1 |
| **TOTAL** | 8 | 9 |

| Medications/Dose/Route | Time | RN |
|---|---|---|
| ☐ Ondansetron 4mg IV | | |
| ☐ Proparacaine 0.5% 1 gtt_____eye | | |
| ☐ ______ | | |
| ☐ ______ | | |

- ☒ Taking PO Fluids — OO
- ☐ Dressing: ☒ Eye Shield Intact ☐ Patch Intact ☐ N/A
- ☐ Ice pack/gauze to operative site ☒ N/A
- ☒ Skin ☒ Warm & Dry ☒ Intact ☐ Other, see notes
- ☒ Verbal & Written DC Instructions given
- ☒ Pt/Caregiver Verbalize understanding of Instructions
- ☐ RX given ☒ N/A
- ☒ MD F/U Appointment verified
- ☒ Post Anesthesia Evaluation by Physician noted
- ☒ Discharge Pain Level: 0 / 10

Comments:______

**Ride home:** [redacted] **Relationship:** daughter **Location:** ☐ **In lobby** ☐ **In car**

[redacted] **Called @**________ **ETA@**________

☐ **Circumstantial Release:** ☐ form signed ☐ pt awake/alert & understands DC Instructions

Patient meets D/C criteria and is released via: ☐ Amb ☒ W/C ☐ Other ________

☒ With all personal belongings

☒ Locker # P2 ☐ **N/A**

IV D/C'd @ 1113 ☒ Catheter Intact

Discharge Time: 1115

[redacted], RN

**R.N Signature**

[redacted] **Surgery Center**

[redacted] MD, [redacted] M [redacted] [redacted], [redacted]

**Postoperative Record** (Revised 06/23)

[redacted]-M000038

CDC Cloth Mask Washing
• Washing Machine – Wash in your regular laundry after each use. Dry in highest heat setting. Or air dry in direct sunlight.
• By hand – Mix bleach solution (1/3 cup per gallon room temp water) Soak for 5 minutes, rinse thoroughly. Then dry.

# Post-op Instructions
## Cataract Surgery

**POST-OP APPOINTMENT**
Date: 6-12-24
Time: 3:05
Location:
Provider:

**CARING FOR YOUR EYE**
1. Wash your hands prior to touching eyes or applying eye drops.
2. Use your eye drops 4 times a day or as directed.
3. Wait 2-3 minutes between each type of eye drop.
4. **DO NOT RUB YOUR EYE**, but you may gently dab your eye with a clean cloth.
5. Use dark glasses when in bright light.
6. Use Tylenol (acetaminophen) or Advil (ibuprofen) for pain if needed.

* Bandage Contact lens in place

7. *If you* are given a clear eye shield (without a patch/dressing) wear it the day of surgery and then at night for 1 week. Use your eyedrops as instructed lifting the shield and replacing it on the day of surgery.
8. *If you* have a patch/dressing over your eye, DO NOT REMOVE IT. Your physician will remove it at your post-op visit and you will start using the eye drops as instructed.

**ACTIVITIES**
1. Do not drive until cleared by your doctor (usually 24 hours after surgery).
2. You may shower and wash your hair or go to the hairdresser.
3. Avoid allowing water to run directly into your eye for one week following surgery.
4. No swimming or wearing eye make-up for one week after surgery.
5. No heavy lifting or strenuous activities such as jogging or aerobics for one week after surgery.
6. No inversion tables for one week after surgery.

**IT IS NORMAL** to experience the following during the healing process:
1. Mild tearing which may be pink in color.
2. Itching and scratchy feeling and redness of the eye.
3. Blurry, distorted, foggy vision.
4. Pink or red glow, halos around lights.
5. Sensitivity to bright lights.
6. Dull ache or pain around the eye for which you can take Tylenol (acetaminophen) or Advil (ibuprofen).
7. Tingling feeling in the hands and feet.
8. Queasy stomach or mild nausea.

**IT IS UNUSUAL** to experience the following:
1. Severe or extreme pain in or around the eye.
2. Progressively worsening vision.
3. Fever of 101 degrees or greater.
4. Severe nausea or vomiting.
5. ANY questions or problems **CALL**

Patient verbalizes und[redacted] and all questions and/or concerns have been addressed.

**Patient Signature:** ______________________ **Date:** JUN 1 1 2024

**Staff Signature:** ______________________ **Date:** JUN 1 1 2024

Surger

Visit Note - April 15, 2025

## Medications

OPHTHALMIC MEDICATIONS
prednisolone acetate 1% drops, suspension

NON OPHTHALMIC MEDICATIONS
amiodarone 200 mg Oral - tablet
Eliquis 5 mg Oral - tablet
levothyroxine 25 mcg Oral - tablet
potassium chloride 20 mEq Oral - tablet, extended release
pravastatin 20 mg Oral - tablet

## Ocular History

Dry eyes
Other: astigmatism;

corneal ulcer OD;

macular edema OU;

Psuedophakia OU

## Ocular Surgery

History of left cataract extraction: CE w IOL 06/2024
History of right cataract extraction: CE w IOL 06/2024

## Social History

Smoking status - Never smoker

## Allergies

No known drug allergies

## Alerts

High blood pressure and blood thinners.

## ROS

Provider reviewed on Apr 15, 2025.

A focused review of systems was performed including Allergic / Immunologic.

No Allergies.

## Medical History

H/O: hypertension
Other: thyroid issues unknown if hypo or hyper he just started on medication 02/2025

## Surgical History

Other: gall bladder removed with stones removed;

PACEMAKER;

## Chief Complaints:

1. Corneal scarring OD
2. Dry Eyes
3. macular edema OD
4. Fall Risk Screening and Assessment

## HPI: This is an 85 year old male who:

1. is being seen for a chief complaint of Corneal scarring OD. VA OD has a foggy film for all distances since his CE w iol in 06/2024.
   Reports most of the time seeing black floaters come and go OD.
   His Dr at [redacted] wants to do cornea transplant but is against it.
   Denies any flashes of light. Using pred BID OD, last used 8am
2. is being seen for a chief complaint of dry eyes, involving the left eye. VA OS is stable for all distances using readers for small print only.
   Reports dry OU comes and goes some times so using refresh PRN OU for relief.
   Denies any pain..
3. is being seen for a chief complaint of macular edema OD. Reports was supposed to see retina specialist but has not seen one yet.
4. has had no falls within the past year. The patient has a MAHC-10 Fall Risk Assessment of 1. Scores less than 4 are considered lower risk for future falls.

## Eye Exam

### Vision

Distance Test Type: Snellen Chart

| | Eye | |
|---|---|---|
| Dsc | OD | 20/200 +1<br>PH: NI<br>blurry |
| | OS | 20/50<br>PH: 20/40 -1<br>blurry |
| | OU | 20/60 blurry |

### Auto Refraction

Binocular PD: 63.0 (Dist) 59.0 (Near)

| Eye | Measurement | DCC | NCC |
|---|---|---|---|
| OD | -18.75 | | |
| OS | -1.00 +2.75 x 107 | | |

### Keratometry

| | Flat | Axis | Steep | Axis | Mires Quality | Method |
|---|---|---|---|---|---|---|
| OD | 42.00 | 153 | 44.75 | 063 | | |
| OS | 44.25 | 014 | 46.50 | 104 | | |

### Manifest Refraction

Binocular PD: 63.0 (Dist) 59.0 (Near)

| Eye | Measurement | HP | HB | VP | VB | SO | VD | MPD-D | MPD-N | DCC | NCC |
|---|---|---|---|---|---|---|---|---|---|---|---|
| OD | -18.75<br>Add: +3.25 | | | | | | 13.75 | | | 20/200 +1 | |
| OS | -1.00 +2.75 x 107<br>Add: +3.25 | | | | | | 13.75 | | | 20/40 | |
| OU | | | | | | | | | | | J4 -1 |

**Notes: NI OD.**

### Pupils: Normal

| | Light (mm) | Dark (mm) | Near (mm) | Size | Round | Regular | Reacts | APD | RAPD | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| OD | | | | Normal | Round | Regular | Reacts Well | No APD | | |
| OS | | | | Normal | Round | Regular | Reacts Well | No APD | | |

IOP

| | | | | |
|---|---|---|---|---|
| OD | 25 | | 04/15/2025 09:08 AM PDT | Pneumotonometer |
| OS | 16 | | 04/15/2025 09:08 AM PDT | Pneumotonometer |
| OD | 25 | | 04/15/2025 09:08 AM PDT | Pneumotonometer |
| OS | 16 | | 04/15/2025 09:08 AM PDT | Pneumotonometer |

Diagnostic Drops

| | Drops Used | Staff | Date | Notes |
|---|---|---|---|---|
| OD | Tropicamide 1%/Phenylephrine 2.5%<br>Proparacaine 0.5% | | 09:07 AM PDT | |
| OS | Tropicamide 1%/Phenylephrine 2.5%<br>Proparacaine 0.5% | | 09:07 AM PDT | |

Patient counseled about blurry vision and problems driving after dilation.

Motility: Full OU

Visual Field Test Type: Confrontation Visual Fields

Visual Field Test Result: Full to Confrontation OU

Pachymetry

| | Central Cornea | Superior Cornea | Nasal Cornea | Inferior Cornea | Temporal Cornea |
|---|---|---|---|---|---|
| OD | 402.0 | | | | |
| OS | 487.0 | | | | |

## Exam:

An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam

OD Lid Margin: quiet and normal

Slit lamp examination OD:

OD Conjunctiva: white and quiet

OD Cornea: central and nasal moderate stromal scarring

OD Anterior Chamber: deep and quiet anterior chamber

OD Iris: normal iris without rubeosis

OD Lens: PCIOL well centered

A dilated exam of the optic disc was performed OD.

Ophthalmoscopic examination of optic disc OD:

OD: CD ratio 0.4

OD Optic Disc: flat and normal disc

A dilated fundus exam was performed OD.

Ophthalmoscopic examination of retina and vessels OD:

OD Vitreous: vitreous clear without hemorrhage, cells or

OS External: normal lid position, nasolacrimal and orbital exam

OS Lid Margin: quiet and normal

Slit lamp examination OS:

OS Conjunctiva: white and quiet

OS Cornea: clear cornea

OS Anterior Chamber: deep and quiet anterior chamber

OS Iris: normal iris without rubeosis

OS Lens: PCIOL well centered

A dilated exam of the optic disc was performed OS.

Ophthalmoscopic examination of optic disc OS:

OS: CD ratio 0.4

OS Optic Disc: flat and normal disc

A dilated fundus exam was performed OS.

Ophthalmoscopic examination of retina and vessels OS:

OS Vitreous: vitreous clear without hemorrhage, cells or

pigment
OD Vessels: vessels with normal contour, caliber without neovascularization
OD Macula: macula normal contour without heme, edema, drusen or exudate
OD Periphery: periphery normal appearance without retinal tears, breaks, holes or mass

pigment
OS Vessels: vessels with normal contour, caliber without neovascularization
OS Macula: macula normal contour without heme, edema, drusen or exudate
OS Periphery: periphery normal appearance without retinal tears, breaks, holes or mass

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Tests

**Corneal Topography**

A same-day order was placed for this diagnostic test.

Diagnostic Procedure: Corneal Topography - OU
Indication: Corneal Scarring OD

Corneal Topography Result OD: astigmatism, irregular and irregular ocular surface
moderate irregular astigmatism

Corneal Topography Result OS: astigmatism, irregular
mild irregular
Reliability: good

Assessment OD: initial study
Assessment OS: initial study

**Corneal Pachymetry**

A same-day order was placed for this diagnostic test.

Diagnostic Procedure: Corneal Pachymetry - OU
Method Used: ultrasound
Indication: Corneal Scarring OD

Central Corneal Thickness OD: thin
Central Corneal Thickness OD: 402 microns

Central Corneal Thickness OS: thin
Central Corneal Thickness OS: 487 microns
Reliability: good

## Orders

1. MIPS
   **Order: MIPS Quality.**

   Quality 155 Part A (Falls: Risk Assessment): Falls risk assessment completed and documented in the past 12 months.

Quality 130 (Documentation of Current Medications in the Medical Record): Current Medications Documented

## Impression/Plan:

1. Corneal Scarring OD - *K scarring OD related to CTL related ulcer (per pt, no records to review) - reviewed options: obs vs SK with CTL vs PKP OD. Discussed unlikely to improve with SK alone but given less invasive procedure ok to attempt. Reviewed r/b/a and pt wishes to proceed with SK OD.*
(H17.89)

**Plan: Counseling - Corneal scarring.**
I counseled the patient regarding the following:
Eye Care: Corneal scarring is often observed without any need for intervention. Rigid gas permeable contact lenses and scleral contact lenses can improve vision in many eyes with scarring. Corneal scarring can sometimes be reduced or eliminated with topical corticosteroid eye drops, or excimer laser PTK. If the scarring is extensive or unresponsive to the previously mentioned treatments, a superficial keratectomy, lamellar keratoplasty, or penetrating keratoplasty may be helpful.
Expectations: Corneal scarring can occur as a result of healing after corneal ulcers, corneal lacerations, corneal foreign bodies, or be associated with corneal dystrophies such as anterior basement corneal dystrophy, Salzmann's nodular corneal dystrophy, and keratoconus.
Contact the office if: Eye pain, redness, loss of vision, or glare occurs.
I discussed the following surgical options with the patient
Corneal scarring Option Other : Superficial Keratectomy

Medical Decision Making - OD
superficial keratectomy

**Plan: Prescription.**
moxifloxacin 0.5 % eye drops Ophthalmic (eye)
Sig: Administer 1 drop into affected eye 4 x a day starting 2 days before surgery
Quantity: 3 Milliliter Refills: 1

prednisolone acetate 1 % eye drops,suspension Ophthalmic (eye)
Location: OD
Sig: Administer 1 drop into affected eye four times a day.
Quantity: 5 Milliliter Refills: 2

**Plan: F/U for Next Visit Cornea.**
Surgical Procedures OD: Superficial Keratectomy.
Other Surgical Procedures OD: 65435

Associated with:
Corneal Topography
Corneal Pachymetry

2. Steroid responder, right eye - *Mildly elevated IOP OD. rec cont pred qday for now, may need IOP drops in future.*
(H40.041)

**Plan: Counseling - Glaucoma.**
I counseled the patient regarding the following:
Eye care: Glaucoma is usually treated with eye drops to lower the eye pressure.
Expectations: Glaucoma is usually a disease of high pressure in the eye that damages the optic nerve and causes loss of peripheral vision and possibly even blindness. Glaucoma treatment with various combinations of eye drops will usually help to lower the eye pressure and prevent further damage. In advanced or poorly controlled cases, laser treatment or conventional glaucoma surgery may be necessary.
Contact Office if: The Glaucoma drops are causing pain, irritation, or blurry vision after use.

After counseling the patient, we decided on the following plan for the right eye: Observation

## Staff:

[redacted], MD (Primary Provider) (Bill Under)

[redacted]:

[redacted], OSC (scribe)

I, [redacted], OSC am scribing for, and in the presence of [redacted], MD.

Electronically Signed By: [redacted], OSC, 04/15/2025 09:41 AM PDT

I, [redacted]r, MD, personally performed the services described in the documentation as scribed by [redacted], OSC in my presence, and confirm it is both accurate and complete.

Electronically Signed By [redacted], 04/15/2025 09:41 AM PDT

# Visit Note - April 21, 2025

Patient Sex DOB MRN

## Medications

OPHTHALMIC MEDICATIONS
moxifloxacin 0.5% 1 Drop drops Every 4 hours
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% 1 Drop drops, suspension Four times a day OD

NON OPHTHALMIC MEDICATIONS
amiodarone 200 mg Oral - tablet
Eliquis 5 mg Oral - tablet
levothyroxine 25 mcg Oral - tablet
potassium chloride 20 mEq Oral - tablet, extended release
pravastatin 20 mg Oral - tablet

## Ocular History

Dry eyes
Other: astigmatism

corneal ulcer OD;

macular edema OU;

Pseudophakia OU

## Ocular Surgery

History of left cataract extraction: CE w IOL 06/2024
History of right cataract extraction: CE w IOL 06/2024

## Social History

Smoking status - Never smoker

## Allergies

No known drug allergies

## Alerts

High blood pressure and blood thinners.

## Medical History

H/O: hypertension
Other: thyroid issues unknown if hypo or hyper he just started on medication 02/2025

## Surgical History

Other: gall bladder removed with stones removed;

PACEMAKER;

## Vitals:

| Date | Taken By | B.P. | Pulse | Resp. | O2 Sat. | Temp. | Ht. | Wt. | BMI | BSA |
|---|---|---|---|---|---|---|---|---|---|---|
| 04/21/25 09:53 | [redacted]es, [redacted] | 145/67 SIT | 69 | 18 | 98.0% | 97.3 F | 70.0 in | 205.0 lbs | 29.4 | 2.1 |
| | FiO2 | | | | | | | | | |
| | Room Air - 21.0% | | | | | | | | | |

* Patient Reported

## Surgery Scheduling Note:

PKP
1st Sx: 6/5
Topical Anesthesia

## Staff:

[redacted] D (Primary Provider) (Bill Under)

Electronically Signed By: [redacted], MD, 04/21/2025 02:46 PM PDT

Visit Note - May 9, 2025

## Medications

OPHTHALMIC MEDICATIONS
moxifloxacin 0.5% 1 Drop drops Every 4 hours
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% 1 Drop drops, suspension Four times a day OD

NON OPHTHALMIC MEDICATIONS
amiodarone 200 mg Oral - tablet
Eliquis 5 mg Oral - tablet
levothyroxine 25 mcg Oral - tablet
potassium chloride 20 mEq Oral - tablet, extended release
pravastatin 20 mg Oral - tablet

## Ocular History

Dry eyes
Other: astigmatism;

corneal ulcer OD;

macular edema OU;

Psuedophakia OU

## Ocular Surgery

History of left cataract extraction: CE w IOL 06/2024
History of right cataract extraction: CE w IOL 06/2024

## Social History

Smoking status - Never smoker

## Allergies

No known drug allergies

## Alerts

High blood pressure and blood thinners.
[illegible]

## Medical History

H/O: hypertension
Other: thyroid issues unknown if hypo or hyper he just started on medication 02/2025

## Surgical History

Other: gall bladder removed with stones removed

PACEMAKER;

## Chief Complaints:

1. procedure

## HPI: This is an 85 year old male who:

1. is being seen for a chief complaint of procedure. Corneal Scarring OD. No pain or discomfort. Says VA looks foggy and looks like he's looking through a cloud. Using oflox QID OD, pred BID OD and refresh TID OU.

## Eye Exam

Vision
Distance Test Type: Snellen Chart

| Dcc | OD | 20/200 |
|---|---|---|
| | OS | 20/40 |

IOP

| | | | |
|---|---|---|---|
| OD | Deferred | 05/09/2025 10:58 AM PDT | Pneumotonometer procedure, SUPER K |
| OS | Deferred | 05/09/2025 10:58 AM PDT | Pneumotonometer procedure, SUPER K |

## Exam:

An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: white and quiet

OD Cornea: central and nasal moderate stromal scarring

OD Anterior Chamber: deep and quiet anterior chamber

OD Iris: normal iris without rubeosis

OD Lens: PCIOL well centered

A dilated exam of the optic disc was performed OD.

Ophthalmoscopic examination of optic disc OD:
OD: CD ratio 0.4
OD Optic Disc: flat and normal disc

A dilated fundus exam was performed OD.

Ophthalmoscopic examination of retina and vessels OD:
OD Vitreous: vitreous clear without hemorrhage, cells or pigment
OD Vessels: vessels with normal contour, caliber without neovascularization
OD Macula: macula normal contour without heme, edema, drusen or exudate
OD Periphery: periphery normal appearance without retinal tears, breaks, holes or mass

OS External: normal lid position, nasolacrimal and orbital exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet

OS Cornea: clear cornea

OS Anterior Chamber: deep and quiet anterior chamber

OS Iris: normal iris without rubeosis

OS Lens: PCIOL well centered

A dilated exam of the optic disc was performed OS.

Ophthalmoscopic examination of optic disc OS:
OS: CD ratio 0.4
OS Optic Disc: flat and normal disc

A dilated fundus exam was performed OS.

Ophthalmoscopic examination of retina and vessels OS:
OS Vitreous: vitreous clear without hemorrhage, cells or pigment
OS Vessels: vessels with normal contour, caliber without neovascularization
OS Macula: macula normal contour without heme, edema, drusen or exudate
OS Periphery: periphery normal appearance without retinal tears, breaks, holes or mass

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:

1. Corneal Scarring OD *- K scarring OD related to CTL related ulcer (per pt, no records to review) - reviewed options: obs vs SK with CTL vs PKP OD. Discussed unlikely to improve with SK alone but given less invasive procedure, ok to attempt. Reviewed r/b/a and pt wishes to proceed with SK OD.*
   [illegible]
   located on the right central cornea.

   **Plan: Counseling - Corneal scarring.**
   I counseled the patient regarding the following:
   Eye Care: Corneal scarring is often observed without any need for intervention. Rigid gas permeable contact lenses and scleral contact lenses can improve vision in many eyes with scarring. Corneal scarring can sometimes be reduced or eliminated with topical corticosteroid eye drops, or excimer laser PTK. If the scarring is extensive or unresponsive to the previously mentioned treatments, a superficial keratectomy, lamellar keratoplasty, or penetrating keratoplasty may be helpful.
   Expectations: Corneal scarring can occur as a result of healing after corneal ulcers, corneal lacerations, corneal foreign bodies, or be associated with corneal dystrophies such as anterior basement corneal dystrophy, Salzmann's nodular corneal dystrophy, and keratoconus.
   Contact the office if: Eye pain, redness, loss of vision, or glare occurs.
   I discussed the following surgical options with the patient:
   Corneal scarring Option Other : Superficial Keratectomy

   Medical Decision Making - OD
   superficial keratectomy

   **Plan: Superficial Keratectomy (Excision of lesion, cornea - keratectomy, lamellar, partial).**
   Procedure: Superficial Keratectomy

   Location: right central cornea

   Preop Diagnosis: other

   Postop Diagnosis: same

   Anesthesia: Alcaine gtts

   Complications: none

   Consent: The risks, benefits and alternatives of superficial keratectomy were discussed with the patient. The patient read and signed the consent form, was identified, and was seated in the exam chair.

   Operative Note
   With the patient reclining in the exam chair the affected eye was prepped with 10% Povidone to the skin. Zymar drops were used to sterilize the ocular surfaceAlcaine gtts were used to obtain adequate topical anesthesia. The lid speculum was inserted. The patient was put upright in the chair and positioned at the slit lamp microscope. A 69 Beaver blade was used to scrape off the epithelium overlying the involved area. The blade was then used to excise: the nodules and any surrounding scar tissue. The blade was then used to smoothe the remaining areas of exposed Bowman's membrane.
   A bandage contact lens was applied to the eye. The patient left the operating room in good condition. The patient was instructed to continue using all the same eye drops as before the procedure. The patient was instructed not to rub their eyes and keep their head dry for 48 hours. The patient was advised to call immediately for any pain, lid swelling or tenderness, discharge, or loss of vision. The patient will return tomorrow for a postoperative exam.

   **Plan: F/U for Next Visit Cornea.**
   The patient should be scheduled for the following on 5-10 days:

2. Steroid responder, right eye *- Mildly elevated IOP OD, rec cont pred qday for now, may need IOP drops in future.*
   (H40.041)

   **Plan: Counseling - Glaucoma.**
   I counseled the patient regarding the following:
   Eye care: Glaucoma is usually treated with eye drops to lower the eye pressure.

Expectations: Glaucoma is usually a disease of high pressure in the eye that damages the optic nerve and causes loss of peripheral vision and possibly even blindness. Glaucoma treatment with various combinations of eye drops will usually help to lower the eye pressure and prevent further damage. In advanced or poorly controlled cases, laser treatment or conventional glaucoma surgery may be necessary.
Contact Office if: The Glaucoma drops are causing pain, irritation, or blurry vision after use.

After counseling the patient, we decided on the following plan for the right eye: Observation

**Staff:**

MD (Primary Provider) (Bill Under)

scribe)

I, M am scribing for, and in the presence of MD.

Electronically Signed By 05/09/2025 03:38 PM PDT

I, MD, personally performed the services described in the documentation as scribed by in my presence, and confirm it is both accurate and complete.

Electronically Signed By: MD, 05/09/2025 03:38 PM PDT

# Visit Note - May 16, 2025

## Medications
OPHTHALMIC MEDICATIONS
moxifloxacin 0.5% 1 Drop drops Every 4 hours
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% 1 Drop drops, suspension Four times a day OD

NON OPHTHALMIC MEDICATIONS
amiodarone 200 mg Oral - tablet
Eliquis 5 mg Oral - tablet
levothyroxine 25 mcg Oral - tablet
potassium chloride 20 mEq Oral - tablet, extended release
pravastatin 20 mg Oral - tablet

## Ocular History
Dry eyes
Other: astigmatism;

corneal ulcer OD;

macular edema OU;

Psuedophakia OU

## Ocular Surgery
History of right cataract extraction: CE w IOL 06/2024
History of left cataract extraction: CE w IOL 06/2024

## Social History
Smoking status - Never smoker

## Allergies
No known drug allergies

## Alerts
High blood pressure and blood thinners -
[illegible]

## Medical History
H/O. hypertension
Other: thyroid issues unknown if hypo or hyper he just started on medication 02/2025

## Surgical History
Other: gall bladder removed with stones removed;

PACEMAKER

## Chief Complaints:
1. PO

## HPI: This is an 85 year old male who:
1. Is being seen for a chief complaint of PO. PO SUPER K 05/09/2025
   VA OD its cloudy. BCL OD.
   Reports some tearing comes and goes. Has not used lubrication in two days.
   Using pred and poly QID OD, last used 8am.

## Eye Exam
Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | 20/200<br>PH: NI<br>blurry |
| | OS | 20/50<br>PH: 20/40<br>blurry |

IOP

| | | | |
|---|---|---|---|
| OD | 22 | 05/16/2025 08:49 AM PDT | Pneumotonometer |
| OS | 16 | 05/16/2025 08:49 AM PDT | Pneumotonometer |
| OD | 19 | 05/16/2025 08:51 AM PDT | Pneumotonometer |
| OS | 14 | 05/16/2025 08:51 AM PDT | Pneumotonometer |

Diagnostic Drops

| | Drops Used | Staff | Date | Notes |
|---|---|---|---|---|
| OD | Proparacaine 0.5% | | 08:47 AM PDT | |
| OS | Proparacaine 0.5% | | 08:47 AM PDT | |

## Exam:
An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: white and quiet
OD Cornea: BCL in place (removed) and central and nasal moderate stromal scarring
OD Anterior Chamber: deep and quiet anterior chamber
OD Iris: normal iris without rubeosis
OD Lens: PCIOL well centered

OS External: normal lid position, nasolacrimal and orbital exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet
OS Cornea: clear cornea
OS Anterior Chamber: deep and quiet anterior chamber
OS Iris: normal iris without rubeosis
OS Lens: PCIOL well centered

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

Visit Note - May 16, 2025

## Impression/Plan:

1. **Postop Superficial Keratectomy OD** - *POW 1 s/p SK OD. doing well. BCL removed. stop abx. cont pred QID. f/u 4-6wks* (Z98.890)

   **Plan: Post Op Evaluation Superficial Keratectomy.**
   OD Postop: week 1
   I recommended the following postoperative plan OD:
   Continue Regimen : Use antibiotic, NSAIDs and steroid drops as scheduled.

   **Plan: F/U for Next Visit.**
   The patient should be scheduled for the following or 4-6 weeks.
   - Nondilate refract - OD

   Diagnostics OD: Corneal Topography.

2. **Steroid responder, right eye** - *Mildly elevated IOP OD. rec cont pred qday for now. may need IOP drops in future.* (H40.041)

   **Plan: Counseling - Glaucoma.**
   I counseled the patient regarding the following:
   Eye care: Glaucoma is usually treated with eye drops to lower the eye pressure.
   Expectations: Glaucoma is usually a disease of high pressure in the eye that damages the optic nerve and causes loss of peripheral vision and possibly even blindness. Glaucoma treatment with various combinations of eye drops will usually help to lower the eye pressure and prevent further damage. In advanced or poorly controlled cases, laser treatment or conventional glaucoma surgery may be necessary.
   Contact Office if: The Glaucoma drops are causing pain, irritation, or blurry vision after use.

   After counseling the patient, we decided on the following plan for the right eye: Observation

## Staff:

[REDACTED] MD (Primary Provider) (Bill Under)

[REDACTED]

[REDACTED], OSC (scribe)

I, [REDACTED] OSC am scribing for, and in the presence of [REDACTED] MD.

Electronically Signed By: [REDACTED] OSC, 05/16/2025 12:13 PM PDT

I, [REDACTED] MD, personally performed the services described in the documentation as scribed by [REDACTED] OSC in my presence, and confirm it is both accurate and complete.

Electronically Signed By: [REDACTED] MD, 05/16/2025 12:13 PM PDT

Visit Note - July 3, 2025

## Medications
OPHTHALMIC MEDICATIONS
moxifloxacin 0.5% 1 Drop drops Every 4 hours
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% 1 Drop drops, suspension Four times a day OD

NON OPHTHALMIC MEDICATIONS
amiodarone 200 mg Oral - tablet
Eliquis 5 mg Oral - tablet
levothyroxine 25 mcg Oral - tablet
potassium chloride 20 mEq Oral - tablet, extended release
pravastatin 20 mg Oral - tablet

## Ocular History
Dry eyes
Other: astigmatism;

corneal ulcer OD;

macular edema OU;

Pseudophakia OU

## Ocular Surgery
History of left cataract extraction: CE w IOL 06/2024
History of right cataract extraction: CE w IOL 06/2024

## Social History
Smoking status - Never smoker

## Allergies
No known drug allergies

## Alerts
High blood pressure and blood thinners.

## Medical History
H/O hypertension
Other: thyroid issues unknown if hypo or hyper he just started on medication 02/2025

## Surgical History
Other: gall bladder removed with stones removed;

PACEMAKER;

## Chief Complaints:
1. PO

## HPI: This is an 85 year old male who:
1. is being seen for a chief complaint of PO. PO 05/09/2025 Superficial Keratectomy OD
VA OD is stable since last visit but vision is never sharp and clear.
Reports fbs comes and goes OD.
Using pred QID OD, last used 8am
OTC PRN OU using some times.

## Eye Exam

### Vision
Distance Test Type: Snellen Chart

| | | |
|---|---|---|
| Dsc | OD | 20/100<br>PH: NI<br>blurry |
| | OS | 20/60 -1<br>PH: 20/40 -1<br>blurry |

### Auto Refraction
Binocular PD: 64.0 (Dist) 60.0 (Near)

| Eye | Measurement | DCC | NCC |
|---|---|---|---|
| OD | Plano | | |
| OS | -1.00 +2.75 x 105 | | |

### Keratometry

| | Flat | Axis | Steep | Axis | Mires Quality | Method |
|---|---|---|---|---|---|---|
| OS | 44.50 | 008 | 47.00 | 098 | | |

### Manifest Refraction
Binocular PD: 64.0 (Dist) 60.0 (Near)

| Eye | Measurement | HP | HB | VP | VB | SO | VD | MPD-D | MPD-N | DCC | NCC |
|---|---|---|---|---|---|---|---|---|---|---|---|
| OD | Plano<br>Add: +3.00 | | | | | | 13.75 | | | 20/100 | |
| OS | -1.00 +2.75 x 105<br>Add: +3.00 | | | | | | 13.75 | | | 20/40 -1 | |
| OU | | | | | | | | | | | J4 -1 |

### IOP

| | | | |
|---|---|---|---|
| OD | 20 | 07/03/2025 09:05 AM PDT | Pneumotonometer |
| OS | 15 | 07/03/2025 09:05 AM PDT | Pneumotonometer |

### Diagnostic Drops

| | Drops Used | Staff | Date | Notes |
|---|---|---|---|---|
| OD | Proparacaine 0.5% | | 09:05 AM PDT | |
| OS | Proparacaine 0.5% | | 09:05 AM PDT | |

## Exam:
An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam
OD Lid Margin: quiet and normal

Slit lamp examination OD:

OS External: normal lid position, nasolacrimal and orbital exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:

OD Conjunctiva: white and quiet

OD Cornea central and nasal moderate stromal scarring

OD Anterior Chamber: deep and quiet anterior chamber

OD Iris: normal iris without rubeosis

OD Lens: PCIOL well centered

OS Conjunctiva: white and quiet

OS Cornea: clear cornea

OS Anterior Chamber: deep and quiet anterior chamber

OS Iris: normal iris without rubeosis

OS Lens: PCIOL well centered

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:

1. Postop Superficial Keratectomy OD - *POW 7 s/p SK OD, doing well. Continue Pred, return in 6-8 weeks for reevaluation and corneal topography.* (Z98.890)

   **Plan: Post Op Evaluation Superficial Keratectomy.**
   OD Postop:
   I recommended the following postoperative plan OD:
   Additional Instructions OD: Continue Pred as discussed.

   **Plan: Refraction - Custom Code.**
   Manifest Refraction was performed OU.
   Indication: Postop Superficial Keratectomy OD

   **Plan: F/U for Next Visit**
   The patient should be scheduled on: 6-8 weeks
   with: Dr. Alder
   Instructions: Post Op Short & Corneal Topography OU.

2. Steroid responder, right eye - *Mildly elevated IOP OD, may continue Pred for now. May need IOP drops in the future.* (H40.041)

   **Plan: Counseling - Glaucoma.**
   I counseled the patient regarding the following:
   Eye care: Glaucoma is usually treated with eye drops to lower the eye pressure.
   Expectations: Glaucoma is usually a disease of high pressure in the eye that damages the optic nerve and causes loss of peripheral vision and possibly even blindness. Glaucoma treatment with various combinations of eye drops will usually help to lower the eye pressure and prevent further damage. In advanced or poorly controlled cases, laser treatment or conventional glaucoma surgery may be necessary.
   Contact Office if: The Glaucoma drops are causing pain, irritation, or blurry vision after use.

   After counseling the patient, we decided on the following plan for the right eye: Observation

**Staff:**

scribing for, and in the presence of, MD.

I MD, personally performed the services described in the documentation as scribed by in my presence, and I confirm the documentation is both accurate and complete.

Electronically Signed By MD, 07/03/2025 02:52 PM PDT

# Visit Note - August 13, 2025

## Medications
OPHTHALMIC MEDICATIONS
moxifloxacin 0.5% 1 Drop drops Every 4 hours
prednisolone acetate 1% drops, suspension
prednisolone acetate 1% 1 Drop drops, suspension Four times a day OD

NON OPHTHALMIC MEDICATIONS
amiodarone 200 mg Oral - tablet
Eliquis 5 mg Oral - tablet
levothyroxine 25 mcg Oral - tablet
potassium chloride 20 mEq Oral - tablet, extended release
pravastatin 20 mg Oral - tablet

## Ocular History
Dry eyes
Other: astigmatism;

corneal ulcer OD;

macular edema OU;

Pseudophakia OU

## Ocular Surgery
History of left cataract extraction: CE w IOL 06/2024
History of right cataract extraction: CE w IOL 06/2024

## Social History
Smoking status - Never smoker

## Allergies
No known drug allergies

## Alerts
High blood pressure and blood thinners.
[illegible]

## Medical History
H/O: hypertension
Other: thyroid issues unknown if hypo or hyper he just started on medication 02/2025

## Surgical History
Other: gall bladder removed with stones removed;

PACEMAKER;

## Chief Complaints:
1. Post op

## HPI: This is an 85 year old male who:
1. Is being seen for a chief complaint of Post op. Returns for f/u Superficial Keratectomy OD with OPD. VA is still blurrier but a little better. No pain and discomfort

   Using
   Refresh PF but hasn't used it in the last month.
   pred QD OD

## Eye Exam
Vision
Distance Test Type: Snellen Chart

| Dsc | OD | 20/150 -1<br>PH: NI<br>blurry |
|---|---|---|
| | OS | 20/60 -2<br>PH: 20/30 -2<br>blurry |

IOP

| | | |
|---|---|---|
| OD | 15 | 08/13/2025 08:25 AM PDT Pneumotonometer |
| OS | 16 | 08/13/2025 08:25 AM PDT Pneumotonometer |

## Exam:
An examination was performed

OD External: normal lid position, nasolacrimal and orbital exam
OD Lid Margin: quiet and normal

Slit lamp examination OD:
OD Conjunctiva: white and quiet

OD Cornea: central and nasal moderate stromal scarring and trace KNV nasal

OD Anterior Chamber: deep and quiet anterior chamber

OD Iris: normal iris without rubeosis

OD Lens: PCIOL well centered

OS External: normal lid position, nasolacrimal and orbital exam
OS Lid Margin: quiet and normal

Slit lamp examination OS:
OS Conjunctiva: white and quiet

OS Cornea: clear cornea

OS Anterior Chamber: deep and quiet anterior chamber

OS Iris: normal iris without rubeosis

OS Lens: PCIOL well centered

General Appearance of the patient is well nourished.

Orientation: alert and oriented x 3.

Mood and affect: no acute distress.

## Impression/Plan:
1. **Postop Superficial Keratectomy OD** - *POM 3 s/p SK OD, doing well with persistent haze OD and only modest improvement post-op. reviewed options at this point: cont obs vs Losartan vs CTL vs PKP.*
   (Z98.890)

   **Plan: Post Op Evaluation Superficial Keratectomy.**



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OD Postop:
I recommended the following postoperative plan OD:
Additional Instructions OD: Continue Pred as discussed.

**Plan: Refraction - Custom Code.**
Manifest Refraction was performed OU.
Indication: Postop Superficial Keratectomy OD

**Plan: F/U for Next Visit.**
The patient should be scheduled in: 6 months
with: Dr. Alder
Instructions: Refract No Dilate, Corneal Topography OU.

2. Steroid responder, right eye - *Mildly elevated IOP OD may continue Pred for now. May need IOP drops in the future.* (H40.041)

**Plan: Counseling - Glaucoma.**
I counseled the patient regarding the following:
Eye care: Glaucoma is usually treated with eye drops to lower the eye pressure.
Expectations: Glaucoma is usually a disease of high pressure in the eye that damages the optic nerve and causes loss of peripheral vision and possibly even blindness. Glaucoma treatment with various combinations of eye drops will usually help to lower the eye pressure and prevent further damage. In advanced or poorly controlled cases, laser treatment or conventional glaucoma surgery may be necessary.
Contact Office if: The Glaucoma drops are causing pain, irritation, or blurry vision after use.

After counseling the patient, we decided on the following plan for the right eye: Observation

**Staff:**

MD (Primary Provider) (Bill Under)

(scribe)

scribing for, and in the presence of, MD.

I, MD, personally performed the services described in the documentation as scribed by in my presence, and I confirm the documentation is both accurate and complete.

Electronically Signed By , MD, 08/13/2025 09:12 AM PDT