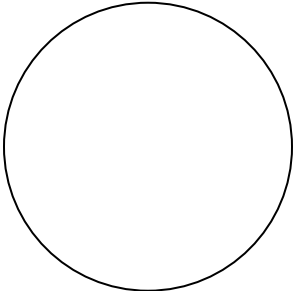


Trabectome® **OPERATIVE** Report Form

PATIENT IDENTIFIERS: Patient Medical Record #: _____ Generic Patient Code #: _____
 (Assigned by NeoMedix)

Investigator: **Dr.** _____ Center: _____ Surgery Date: ____/____/____
 (MM / DD / YY)

Operative Eye O.D. (right) <input type="checkbox"/> O.S. (left) <input type="checkbox"/>	Problems during surgery: yes no Anterior segment bleeding <input type="checkbox"/> <input type="checkbox"/> (other than collector channel reflux) Iris damage <input type="checkbox"/> <input type="checkbox"/> Lens damage <input type="checkbox"/> <input type="checkbox"/> Corneal damage <input type="checkbox"/> <input type="checkbox"/> Other: (specify) _____ _____ _____ _____
Handpiece Lot Number: _____ Electrosurgical Serial No. _____ TB _____ Irrigation Aspiration Serial No. _____ Power Setting: _____ Bottle Height Setting: _____ Aspiration Setting: _____ Viscoelastic type: _____ Gonioscope used? Right: _____ Left: _____	Pre-op medication: Post-op medication: Antibiotic yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Corticosteroid yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Pilocarpine yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Alpha agonist yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> NSAIDS yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Other yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> If other, describe: _____
Incision Type: _____ Trabecular Meshwork Opening degrees: _____	Blood Reflux Present: yes <input type="checkbox"/> no <input type="checkbox"/> Wound Suture: yes <input type="checkbox"/> no <input type="checkbox"/> Air Tamponade: yes <input type="checkbox"/> no <input type="checkbox"/> Other surgical procedures performed: yes <input type="checkbox"/> no <input type="checkbox"/> If yes, describe: _____ _____
Intraocular Medication: yes <input type="checkbox"/> no <input type="checkbox"/> If yes, describe: _____	If procedure not completed, indicate reasons: _____ _____
Ease of use of entry to Schlemm's Canal: Easy <input type="checkbox"/> Moderate <input type="checkbox"/> Difficult <input type="checkbox"/> Comments: _____	Estimated surgical arc: (drawing & degrees) (Superior) 
Ease of trabecular meshwork removal Easy <input type="checkbox"/> Moderate <input type="checkbox"/> Difficult <input type="checkbox"/> Comments: _____	
Ease of Surgical Procedure: Easy <input type="checkbox"/> Moderate <input type="checkbox"/> Difficult <input type="checkbox"/> Comments: _____	
_____ Date: ____/____/____ Signature of Investigator (MM/DD/YY)	