

**PHILIPPINE ACADEMY OF OPHTHALMOLOGY**  
**Committee On Community Ophthalmology**  
**Missions Coordinating Center**  
**PAO MISSION FORM 3: OUTPUT REPORT**

**ID CODE :**

YEAR: _____
MONTH: _____
NUMBER: _____

Inclusive Mission Date/s		Head of Mission	
Name of Health Facility		Sponsor	
Address			

\* This report shall be submitted 1 week after mission date.

No	PATIENT (FULL NAME)	AGE	SEX	DIAGNOSIS	EYE		PROCEDURE	DISPOSITION			DATE	SURGEON
					RT	LE		IMPR	WORSE	UNDET		

# MISSION CENSUS

## 1. PATIENTS

		Number of Cases
Number of medical patients	Adults	
	Pediatric	
Number of surgical patients	Adult	
	Pediatric	
TOTAL NUMBER OF PATIENTS		
	Male	
	Female	

## 2. MANAGEMENT GIVEN

2A. MEDICAL		Number of Cases
Out-patient consultation		
Refracted		
Referred		
	To local ophthalmologist	
	To optometrist	
TOTAL NUMBER OF MEDICAL PATIENTS		

2B. SURGICAL		Number of Cases	
		with IOL	w/o IOL
Cataract	Phaco		
	ECCE		
	ICCE		
	SICS		
	Lensectomy		
Strabismus			
Chalazion			
Pterygium			
TOTAL NUMBER OF SURGICAL PATIENTS			

## 3. COMPLICATIONS

	Number of Cases
None	
Capsular rupture	
Vitreous loss	
Corneal edema	
Iridodiolysis	
Hyphema	
Glaucoma	
Choroidal bleeding	
Expulsive hemorrhage	
Retinal detachment	
Endophthalmitis	
Others:	
TOTAL NUMBER OF PATIENTS	

## 5. REMARKS/COMMENTS/PROBLEMS


## REPORT PREPARED BY:

NAME	
SIGNATURE	
CONTACT #	
DATE	