REFRACTIVE POST-PROCEDURE REPORT

Patient Name: ____________________ Patient's Date of Birth: ____/____/____ Age: ______

Co-Managing Doctor: ____________________ Contact: ☐ Doctor ☐ Assistant: ____________________

Doctor Email: ____________________ Doctor Phone: ____________________

Procedure Information:

RIGHT EYE	LEFT EYE
Procedure Date: __________ Aim: ☐ Distance Piano ☐ Monovision	Procedure Date: __________ Aim: ☐ Distance Piano ☐ Monovision
Original RX: __________ 20/	Original RX: __________ 20/

Post-Operative Exam and Comments:

RIGHT EYE	LEFT EYE
Exam Date: __________ Day: 1 2 3 4 5 6 Month: 1 2 3 12	Exam Date: __________ Day: 1 2 3 4 5 6 Month: 1 2 3 12
Patient Remarks: __________	Patient Remarks: __________
Steroid: __________ QID TID BID QD Q2D Nil	Steroid: __________ QID TID BID QD Q2D Nil
Antibiotic: __________ QID TID BID QD Q2D Nil	Antibiotic: __________ QID TID BID QD Q2D Nil
UCVA: 20/ ______ Blurry / Glare / Double / Fluctuating Vision	UCVA: 20/ ______ Blurry / Glare / Double / Fluctuating Vision
Auto Refraction: __________	Auto Refraction: __________
Manifest: __________ 20/ IOP: ______ @	Manifest: __________ 20/ IOP: ______ @

LASIK	LASIK
BIOMICROSCOPY: / ***FLAP CONDITION:***	***BIOMICROSCOPY:*** / ***FLAP CONDITION:***
Adnexa: Normal / Other: — Position excellent dislodged striae	Adnexa: Normal / Other: — Position excellent dislodged striae
Lids/Lashes: Normal / Other: — Clarity clear edema haze	Lids/Lashes: Normal / Other: — Clarity clear edema haze
Conjunctiva: Normal / Other: — Interface clear opacities epi ingrowth	Conjunctiva: Normal / Other: — Interface clear opacities epi ingrowth
Tear Film: Normal /Dry: — Edges smooth rolled eroded	Tear Film: Normal /Dry: — Edges smooth rolled eroded
Anterior Chamber: Deep Quiet / Other:	Anterior Chamber: Deep Quiet / Other:

PRK	PRK
☐ Epithelium ☐ SPK ☐ Haze ☐ Cornea Closed	☐ Epithelium ☐ SPK ☐ Haze ☐ Cornea Closed

RIGHT EYE	LEFT EYE
Doctor's Impression: ☐ Excellent ☐ Stable ☐ Enhancement ☐ Other:	Doctor's Impression: ☐ Excellent ☐ Stable ☐ Enhancement ☐ Other:
Treatment: __________	Treatment: __________
Follow Up: ______ Days / Weeks / Months ☐ Co-Managing Doctor ☐ Surgeon	Follow Up: ______ Days / Weeks / Months ☐ Co-Managing Doctor ☐ Surgeon

Comments:

Doctor Signature: ____________________ Date: __________