Refractive Post Procedure Report

MEDICAL EYE CENTER

COMANAGING DOCTOR _____

PATIENT'S NAME _____ DOB _____

PROCEDURE: ❑ LASIK ❑ PRK DATE:_____

POST-OP EXAM DATE: _____ MEDS: _____

PRIOR TO SURGERY PATIENT WAS: ❑ HYPEROPE ❑ MYOPE ❑ EMMETROPE

F/U: Day 1 2 3 4 Week 1 2 3 4 Month 1 2 3 4 6 9 12

Patient Comments: _____

Visual Acuity, uncorrected: OU _____ OD _____ OS _____

Refraction: OD_____20/_____ OS_____ 20/_____

Cyclo-Refraction: OD_____20/_____ OS_____ 20/_____

Monovision: Dominate eye OD OS

OD:

IOP: (no earlier than 1 month)
Conj: ❑ Clear ❑ Injected ❑ Heme
Epi: ❑ Intact ❑ SPK ❑ Defect
Flap: ❑ In place ❑ Striae ❑ Dislocated
Debris: ❑ None/Min ❑ +1 ❑ +2 ❑ +3
Other: ❑ Ingrowth ❑ Haze; trace, +1, +2, +3

Other:_____

OS:

IOP: (no earlier than 1 month)
Conj: ❑ Clear ❑ Injected ❑ Heme
Epi: ❑ Intact ❑ SPK ❑ Defect
Flap: ❑ In place ❑ Striae ❑ Dislocated
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Other:_____

Recommend: ❑ F/U with comanaging doc in: 1 2 3 4 5 6 days wks mos yrs
❑ F/U with surgeon: ❑ Please call ❑ Scheduled on_____
❑ Medication change:
❑ Enhancement (stable refraction, ≥ 3 mos post-op, we will contact patient)

Comments: _____

Please fax to 541-210-8290