BURLINGTON
LASER EYE CENTRE

LASIK POST-OPERATIVE FORM

Tel: 888-636-4733 • Fax: 905-632-9778

Patient Name _____ **Age** _____ **Tx:** ◯ LASIK ◯ ENHANCEMENT

Co-Managing Doctor _____ **Doctor Phone** _____ **Doctor Fax** _____ **Doctor Email** _____

Original Treatment Date _____ **Post-operative Date** _____

Original Rx OD: _____ 20/ _____ OS: _____ 20/ _____

Meds / Dosage: ◯ Pred Forte _____ ◯ FML 0.1 _____ ◯ Zymar _____ ◯ Artificial Tears: ☐ PF ☐ Regular _____

	OD **Target:** ◯ Plano ◯ Other _____	**OS** **Target:** ◯ Plano ◯ Other _____
UCDVA	**20 /** ◯ **blurry** ◯ **glare** ◯ **dbl** ◯ **fluctuates**	**20 /** ◯ **blurry** ◯ **glare** ◯ **dbl** ◯ **fluctuates**
Refraction	_____ **20 /**	_____ **20 /**
SLIT LAMP	**LASIK Corneal Flap:** Position: ◯ excellent ◯ dislodged ◯ striae Clarity: ◯ clear ◯ edema ◯ haze Interface: ◯ clear ◯ opacities ◯ epithelial ingrowth Edges: ◯ smooth ◯ rolled ◯ eroded **KAMRA:** Position: ◯ well centred ◯ displaced ◯ >0.5mm Haze: ◯ None ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+	**LASIK Corneal Flap:** Position: ◯ excellent ◯ dislodged ◯ striae Clarity: ◯ clear ◯ edema ◯ haze Interface: ◯ clear ◯ opacities ◯ epithelial ingrowth Edges: ◯ smooth ◯ rolled ◯ eroded **KAMRA:** Position: ◯ well centred ◯ displaced ◯ >0.5mm Haze: ◯ None ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+
IOP	_____ **mmHg**	_____ **mmHg**

Next followup visit scheduled: _____ ◯ day ◯ week ◯ month ◯ year **Follow up required with BLEC?** ◯ Y ◯ N

Doctor's Comments/Treatment: ◯ excellent ◯ stable ◯ enhancement

_____

_____

OD Signature _____ **Date** _____