LASIK POST-OPERATIVE FORM

Tel: 888-636-4733 • Fax 905-632-9778

Patient Name:______________________________ Age:____________ Tx: ❑ LASIK ❑ ENHANCEMENT

Co-Managing Doctor:________________________ Dr. Phone:____________________

Dr. Fax:____________________Dr. Email:___________________________

Original Treatment Date: D:_____M:_____Y:_____ Postoperative Visit: D:_____M:_____Y:_____

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/
SLIP LAMP	**LASIK Corneal Flap:** (circle) 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:** (circle) 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 Followup required with BLEC: **Y / N**

Doctors comments/Treatment: Excellent/stable/enhancement ______________________________

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D:_____M:_____Y:________ OD Signature__________________________