BURLINGTON
LASER EYE CENTRE

PRK POST - OPERATIVE FORM

Tel: 888-636-4733 • Fax: 905-632-9778

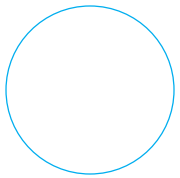
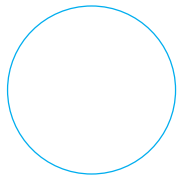
Name:_____ Age:_____ Tx: PRK ❑ OD ❑ OS ❑ OU

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

Original Treatment Date:_____ Postoperative Visit Day:_____/ Week_____/ Month _____

Med: / Dosage: Maxidex_____/ Zymar_____/ Other _____/ 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	CORNEAL CLARITY  HAZE GRADE ❑ Clear ❑ Trace Reticular ❑ Mild Reticular ❑ Moderate Confluent ❑ Severe Confluent HAZE PATTERN ❑ Diffuse ❑ Focal ❑ Arcuate	CORNEAL CLARITY  HAZE GRADE ❑ Clear ❑ Trace Reticular ❑ Mild Reticular ❑ Moderate Confluent ❑ Severe Confluent HAZE PATTERN ❑ Diffuse ❑ Focal ❑ Arcuate
IOP	mmHg	mmHg

Next followup visit scheduled: _____ day / week / month / year Followup required with BLEC: Y N

Doctors comments / Treatment: excellent / stable / enchancement _____

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