

REFRACTIVE SURGERY POST-OP FORM
FAX to: (913) 897-9233

Patient Name: _____ Age: _____ Date: _____ Postop Visit: _____

Procedure Type: _____ Surgery Date: _____ Co-Manage Dr.: _____

Comments: _____ Meds: _____

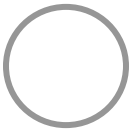
VA sc OD 20/ _____ OU 20/ _____ Near OD J _____ OU J _____ IOP OD _____ mm Hg
OS 20/ _____ OS J _____ OS _____ mm Hg

Keratometry OD: _____ OS: _____

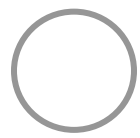
Manifest Rx OD: _____ 20/ _____ Cycloplegic Rx OD: _____
OS: _____ 20/ _____ OS: _____

Slit Lamp Examination

OD
Conj: WNL Other _____
Cornea: WNL _____



OS
Conj: WNL Other _____
Cornea: WNL _____



LASIK Flap (circle)
Position: smooth/centered dislodged striae
Clarity: clear edema haze
Interface: clear opacities epithelial ingrowth
Edges: smooth rolled eroded

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Lens: WNL _____
Retina: WNL _____

Lens: WNL _____
Retina: WNL _____

Impression: _____

Plan: _____

RTC: _____ Dictated: Y N

Signature: _____

Refractive Surgery Post-op Visit

Date: _____ Postop Visit: _____

Comments: _____ Meds: _____

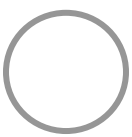
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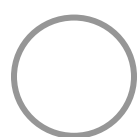
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