Post-Operative Exam

Keratoconus Surgery

Patient Information

name

dob (mm/dd/year) phone

date of procedure

date of this exam

Referring Information

practice name

referring doctor

office phone/fax

office contact

Procedure Performed CXL Intacs Eye(s) Treated OD OS OU

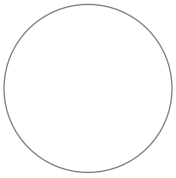
Medications & Comments

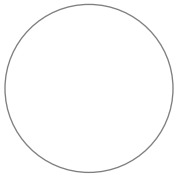
Clinical Findings: **OU** Dist 20/_____

UCVA **OD** Dist 20/_____ **OS** Dist 20/_____

Manifest Refraction _____20/_____ _____20/_____

IOP _____ mmHG _____ mmHG





INTACS **Please Circle All That Apply**

Segment Position -2 -1 0 +1 +2 OD/OS

Incision Suture Tight Normal Gape Cyst

Channel Haze 0 1 2 3 4

Channel Deposit 0 1 2 3 4

CXL **Please Circle All That Apply**

Cornea Clear Haze – Trace 1 2 3 4 OD/OS/OU

Epithelium _____mm Defect Intact OD/OS/OU

Assessment & Plan

doctor signature date

Please contact us by telephone if you require assistance with any post-operative condition. O 405.842.6060 F 405.842.6130