



Post-Operative Exam Refractive 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 LASIK LASIK Retreat PRK KAMRA Eye(s) Treated OD OS OU

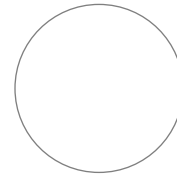
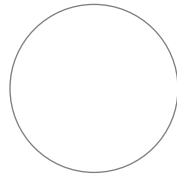
Medications & Comments

Clinical Findings: **OU** Dist 20/_____ Near 20/_____ Target **OD** Plano / Mono **OS** Plano / Mono

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

Manifest Refraction _____ 20/_____ _____ 20/_____

IOP _____ mmHG ADD _____ 20/_____ _____ mmHG ADD _____ 20/_____



LASIK Flap Please Circle All That Apply

Position Excellent / Dislodged / Micro-Striae OD/OS/OU

Clarity Clear / Edema / Haze / Infiltrate OD/OS/OU

Interface Clear / Opacities / Epi-Ingrowth / DLK OD/OS/OU

Edges Smooth / Rolled / Eroded OD/OS/OU

PRK Please Circle All That Apply

Infiltrate NA/OD/OS/OU (immed. referral to nJoy)

Epi-Defect NA/OD/OS/OU size _____mm

BCL in place NA/OD/OS/OU

Haze NA/OD/OS/OU Grade 1/2 / 3 / 4

KAMRA *Position* well centered / displaced > 0.5mm

Haze NA / 1+ / 2+ / 3+ / 4+

| | |
|-------------------|---|
| Assessment & Plan | |
| | <p>_____ date _____</p> <p>doctor signature</p> |