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

Eye(s) Treated OD OS OU

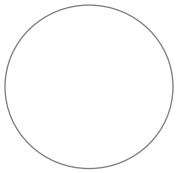
Medications & Comments

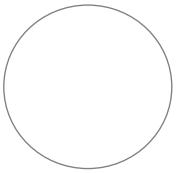
Clinical Findings: **OU** Dist 20/_____ Near 20/_____ Target **OD** Plano / Mono **OS** Plano / Mono

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

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