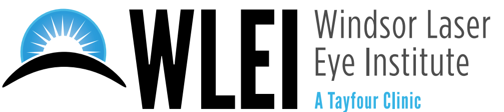

Post-operative Evaluation

Exam Date: ______________________ Comanagement Fees Received: Yes / No

Month: 1 3 6 12 Other ________ Patient Name: ______________________

Doctor Name: ______________________ Phone (H) ______________________

Office Contact: ______________________ Phone Day: ______________________

Office Phone: ______________________ Birthdate: ______________ Age ______

Original Procedure Date: ______________________ Gender: ❒ Male ❒ Female

Enh. Procedure Date: ______________________

Pre-Procedure RX

	SPHERE	CYL.	AXIS	BCVA
OD				20/
OS				20/

UCVA OD 20/ OS 20/

Patient Comments: ______________________

____

____

Subjective Refraction

	SPHERE	CYL.	AXIS	
OD				20/
OS				20/

Cyclopleglic Refraction

(At the 3 month post-operative exam if vision is not satisfactory or if enhancement is considered.)

	SPHERE	CYL.	AXIS	
OD				20/
OS				20/

Slit Lamp Exam

OD

______ I.O.P. ______

OD	OS
Clear	Clear
Haze	Haze
Debris	Debris
Ingrowth	Ingrowth

OS

Meds ❒ Tobradex ❒ Artificial Tears ❒ Other ______________

Doctor Comments: ______________________

____

Requesting Enhancement: ❒ Yes ❒ No ______________________

For Office Use: Recommended Procedure: ______________ Notified Patient: ______________ Notified OD: ______________

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