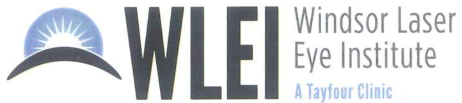

Post-operative Evaluation

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: ______________________ LASIK ☐ PRK ☐ CXL ☐

Pre-Procedure RX

	SPHERE	CYL.	AXIS	BCVA		SPHERE	CYL.	AXIS	BCVA
OD				20/	OS				20/

UCVA OD 20/ OS 20/

Patient Comments: ______________________

____

Subjective Refraction

	SPHERE	CYL.	AXIS			SPHERE	CYL.	AXIS	
OD				20/	OS				20/

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

	SPHERE	CYL.	AXIS			SPHERE	CYL.	AXIS	
OD				20/	OS				20/

Slit Lamp Exam

OD ____________ I.O.P ____________ OS

OD	OS
Clear	Clear
Haze	Haze
Debris	Debris
Ingrowth	Ingrowth

Meds Tobradex ☐ Artificial Tears ☐ Other: ______________

Doctor Comments: ______________________

____

Requesting Enhancement: Yes ☐ No ☐ ______________________

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

2224 Walker Road, Suite 198, Windsor, Ontario N8W 3P6 Email: info@wlei.com
Toll Free: 800-663-I-SEE (4733) Phone: (519) 252-2020 Fax: (519) 252-2091

wlei.com