LASER VISION
LONDON

LASIK POST-OPERATIVE FORM

Tel: 519-204-7777 • Fax: 519-204-1010

Patient Name _____ **Age** _____ **Tx:** ◯ LASIK ◯ ENHANCEMENT

Co-Managing Doctor _____ **Doctor Phone** _____ **Doctor Fax** _____ **Doctor Email** _____

Original Treatment Date _____ **Post-operative Date** _____

Original Rx **OD:** _____ **20/** _____ **OS:** _____ **20/** _____

Meds / Dosage: ◯ Pred Forte _____ ◯ Zymar _____ ◯ Artificial Tears: ☐ PF ☐ Regular _____

	OD Target: ◯ Plano ◯ Other _____	**OS Target:** ◯ Plano ◯ Other _____
UCDVA	**20 /** ◯ **blurry** ◯ **glare** ◯ **dbl** ◯ **fluctuates**	**20 /** ◯ **blurry** ◯ **glare** ◯ **dbl** ◯ **fluctuates**
Refraction	_____ **20 /**	_____ **20 /**
SLIT LAMP	**LASIK Corneal Flap:** Position: ◯ excellent ◯ dislodged ◯ striae Clarity: ◯ clear ◯ edema ◯ haze Interface: ◯ clear ◯ opacities ◯ epithelial ingrowth Edges: ◯ smooth ◯ rolled ◯ eroded	**LASIK Corneal Flap:** Position: ◯ excellent ◯ dislodged ◯ striae Clarity: ◯ clear ◯ edema ◯ haze Interface: ◯ clear ◯ opacities ◯ epithelial ingrowth Edges: ◯ smooth ◯ rolled ◯ eroded
IOP	_____ **mmHg**	_____ **mmHg**

Next followup visit scheduled: _____ ◯ day ◯ week ◯ month ◯ year **Follow up required with LVL?** ◯ Y ◯ N

Doctor's Comments/Treatment: ◯ excellent ◯ stable ◯ enhancement

_____

_____

OD Signature _____ **Date** _____