

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Tx: LASIK ENHANCEMENT

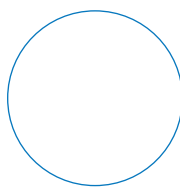
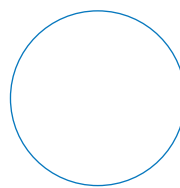
Co-Managing Doctor \_\_\_\_\_ Doctor Phone \_\_\_\_\_ Doctor Fax \_\_\_\_\_ Doctor Email \_\_\_\_\_

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	<b>LASIK Corneal Flap:</b> Position: excellent dislodged striae Clarity: clear edema haze Interface: clear opacities epithelial ingrowth Edges: smooth rolled eroded 					<b>LASIK Corneal Flap:</b> 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 \_\_\_\_\_