PRK POST-OPERATIVE FORM

Tel: 519-204-7777 • Fax: 519-204-1010

Name ______________________ **Age** ______________ **Tx:** PRK OD OS OU

Co-Managing Doctor ______________ **Doctor Phone** ____________ **Doctor Fax** ____________ **Doctor Email** ____________

Original Treatment Date ____________ **Post-operative Visit** **Day** __________ **Week** __________ **Month** __________

Med. / Dosage: Pred Forte ________ Zymar ________ Acular/Voltaren ________ FML ________

Artificial Tears: PF Regular __________

OD **Target:** Plano Other __________ **OS** **Target:** Plano Other __________

	OD			OS		
UCDVA	**20 /** **blurry** **glare** **dbl** **fluctuates**			**20 /** **blurry** **glare** **dbl** **fluctuates**		
Refraction	______________ **20 /**			______________ **20 /**		
SLIT LAMP	**CORNEAL CLARITY**	**HAZE GRADE**	**HAZE PATTERN**	**CORNEAL CLARITY**	**HAZE GRADE**	**HAZE PATTERN**
		Clear Trace Reticular Mild Reticular Moderate Confluent Severe Confluent	Diffuse Focal Arcuate		Clear Trace Reticular Mild Reticular Moderate Confluent Severe Confluent	Diffuse Focal Arcuate
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

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Dr. Signature ______________________________ **Date** ______________

PRK_01_2021