



LASIK POST-OPERATIVE FORM

P 613-509-1313 | F 613-663-2971 | 1-844-319-5683 (LOVE)

Patient Name _____ D.O.B. _____ Tx: LASIK ENHANCEMENT

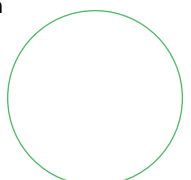
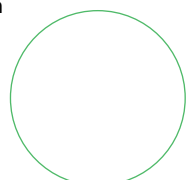
Co-Managing Dr. _____ Dr. Phone _____ Dr. Fax _____ Dr. Email _____

Surgery Date _____ Post-op Visit: Day 1 Week 1 Month 1 Month 3 Month 12 Other _____

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

Meds / Dosage: Tobradex _____ 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	<p>LASIK Corneal Flap:</p> <p>Position: excellent dislodged striae</p> <p>Clarity: clear edema haze</p> <p>Interface: clear opacities epithelial ingrowth</p> <p>Edges: smooth rolled eroded</p> 	<p>LASIK Corneal Flap:</p> <p>Position: excellent dislodged striae</p> <p>Clarity: clear edema haze</p> <p>Interface: clear opacities epithelial ingrowth</p> <p>Edges: smooth rolled eroded</p> 
IOP	_____ mmHg	_____ mmHg

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

Doctor's Comments/Treatment: excellent stable enhancement

OD Signature _____ Date _____