LASER OTTAWA VISION EXPERTS

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	**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 LOVE? ☐ Y ☐ N

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

_____

_____

OD Signature _____ Date _____