Lasik Vision Centers of Cleveland

Lasik Post Op

FAX To 216.674.6410

Patient : _____ Date of birth : _____ Age : _____

Affiliate :_____ Phone : _____ Fax : _____

OD

Procedure date :_____ Target : Distance / Mono

Procedure type : Initial / Enhancement

PostOp date: _____ Day___ / Week____/ Month____ (from surgery)

Patient Comments : _____

Meds : _____

_____

UCVA: 20/_____ Manifest (Wet / Dry) _____ 20/

Refraction (1 mo& 3mo)_____20/____

Biomicroscopy

Adnexia : Normal / Other

Conjuctiva : Normal / Other

Tear Film : Normal / Dry

IOP : _____ @

Flap evaluation

Position : Excellent / Decentered

Clarity : Clear / Edema / Haze

Edges : Smooth / Rolled

Summary : Excellent / Stable / Refer to LVC / Other

Treatment / Follow up / Comments : _____

_____

Affiliate Signature : _____

OS

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_____

Date : _____