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

Dominant Eye: OD / OS Initial / Enhancement

Post Op Date: _____/_____ Day/ Week/ Month/ Year

Best Corrected VA (pre sx) 20/_____

Patient Comments: _____

_____

Meds : _____

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

OS

Procedure date :_____ Target : Distance / Mono

Initial / Enhancement

Post Op Date: _____/_____ Day/ Week/ Month/ Year

Best Corrected VA (pre sx) 20/_____

Patient Comments: _____

_____

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Clarity : Clear / Edema / Haze

Edges : Smooth / Rolled

Summary : Excellent / Stable / Refer to LVC / Other

Treatment / Follow up / Comments: _____

_____

_____

Affiliate Signature : _____ Date : _____