

Post Op Refractive Assessment Report

Procedure: PRK Custom LASIK with IntraLase

Patient Information

Name _____ Date _____ DOB ____/____/____

Surgeon _____ Co-Managing Doctor _____

Right Eye Left Eye Both Eyes

This Visit _____ Days Week 1 Month 3 Month 6 Month 9 Month 12 Month

Vision Assessment

Uncorrected Vision: OD 20/ OS 20/

Best Corrected Vision: OD 20/ OS 20/

Manifest Refraction: OD _____ OS _____

Exam

I.O.P Reading: OD _____ OS _____

Corneal Flap: OD _____ Smooth _____ Clear _____ Other _____

OS _____ Smooth _____ Clear _____ Other _____

Ocular Medication (After this Visit)

Please indicate dosage:

Meds			
Right Eye			
Left Eye			

Comments _____

Examining Doctor _____ Date _____

Signature _____ Please Fax to: 231-733-0566