Shoreline Vision
Vision Care. For Life.™

POST OP REFRACTIVE ASSESSMENT REPORT

Procedure: **PRK** **Custom LASIK with IntraLase**

PATIENT INFORMATION

NAME _____ DATE _____ DOB ___/___/___

SURGEON _____ CO-MANAGING DOCTOR _____

(CIRCLE ONE) RIGHT EYE LEFT EYE BOTH EYES

(CIRCLE ONE) THIS VISIT _____DAYS WEEK 1 MO 3MO 6MO 9MO 12MO

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 MEDICATIONS (AFTER THIS VISIT) please indicate dosage:

MEDS			
RIGHT EYE			
LEFT EYE			

COMMENTS _____

_____

EXAMINING DOCTOR _____ DATE _____

SIGNATURE _____ PLEASE FAX TO: 231-733-0566