independent VISION GROUP

# LASER – LASIK
## Post-Procedure Care

Patient Name _____ Patient's Birth Date: _____/_____/_____ Age: _____

Co-Managing Doctor: _____ Contact: ☐ Doctor ☐ Assistant: _____

Doctor's Phone: _____ Doctor's Fax: _____ Doctor's Email: _____

## Procedure Information

### RIGHT EYE

Procedure Date: _____ Aim: ☐ Distance Plano ☐ Monovision

☐ Primary LASIK Original RX: _____ 20/ _____

☐ Repeat LASIK Enhancement RX: _____

### LEFT EYE

Procedure Date: _____ Aim: ☐ Distance Plano ☐ Monovision

☐ Primary LASIK Original RX: _____ 20/ _____

☐ Repeat LASIK Enhancement RX: _____

## Post Operative Exam and Comments

### RIGHT EYE

Exam Date: _____ Day: 1 2 3 4 5 Month: 1 2 3 or: _____

Patient Remarks: _____

MEDS: _____ QID TID QD Q2D Nil

MEDS: _____ QID TID QD Q2D Nil

UCVA: 20/ _____ Blurry / Glare / Double / Fluctuating Vision

Auto Refraction: _____

Manifest (Wet / Dry): _____ 20/ _____

***BIOMICROSCOPY:*** _____ ***FLAP CONDITION:***

**Adnexa:** Normal / Other: _____ **Position** excellent dislodged striae

**Lids/Lashes:** Normal / Other: _____ **Clarity** clear edema haze

**Conjunctiva:** Normal / Other: _____ **Interface** clear opacities epi ingrowth

**Tear Film:** Normal / Dry _____ **Edges** smooth rolled eroded

**Anterior Chamber:** Deep Quiet / Other: _____

IOP: _____ @ _____

Doctor's Impression: ☐ Excellent ☐ Stable ☐ Enhancement ☐ Other: _____

Treatment: _____

Follow Up: _____ Days / Weeks / Months ☐ With Co-Managing Doctor

☐ Follow Up with IVG-LASIK ☐ Patient will Contact IVG-LASIK ☐ IVG to contact Patient

Comments: _____

Doctor Signature: _____ Date: _____

### LEFT EYE

Exam Date: _____ Day: 1 2 3 4 5 Month: 1 2 3 or: _____

Patient Remarks: _____

MEDS: _____ QID TID QD Q2D Nil

MEDS: _____ QID TID QD Q2D Nil

UCVA: 20/ _____ Blurry / Glare / Double / Fluctuating Vision

Auto Refraction: _____

Manifest (Wet / Dry): _____ 20/ _____

***BIOMICROSCOPY:*** ***FLAP CONDITION:***

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Treatment: _____

Follow Up: _____ Days / Weeks / Months ☐ With Co-Managing Doctor

☐ Follow Up with IVG-LASIK ☐ Patient will Contact IVG-LASIK ☐ IVG to contact Patient

Comments: _____

Doctor Signature: _____ Date: _____

IVG-LASIK is committed to providing the best care and results possible. **Please FAX this completed form to IVG-LASIK at 715-449-8400**. Nomograms are dependent on your post-op data.