



Primary Eye Care Provider Refractive Surgery Follow Up

Patient Name (Dr./ Mr./Mrs./Ms./ Miss): _____

DOB (m/d/y): _____ Examination Date: _____

Assessing Doctor: _____ OD MD

Surgery Date: _____ Type: LASIK PRK ICL RLE Other

EXAMINATION		OD	OS	
Visual Acuity Without Correction		_____	_____	
Manifest Refraction		_____	_____	
Intraocular Pressure		_____ mm Hg	_____ mm Hg	
Ocular Medications:	Current	_____	_____	
LASIK	Interface clear	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Flap smooth	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Flap in good condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PRK	Haze Grading (please specify)	<input type="checkbox"/> Clear <input type="checkbox"/> Mild <input type="checkbox"/> Marked	<input type="checkbox"/> Clear <input type="checkbox"/> Mild <input type="checkbox"/> Marked	
	RLE / ICL	Iridotomy/s patent (ICL only)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		IOL/ICL centred	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crystalline lens grading (ICL only)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Periphery intact		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vaulting grading	_____ + Vaulting	_____ + Vaulting	
	(Visual estimate of space between back surface of ICL and front of crystalline lens, i.e., If space is 2x central ICL thickness, then 2+ vault)			
	Toric ICL orientation (in degrees)	_____ Degrees	_____ Degrees	

Comments or questions: _____

Treatment plan: _____

Is the patient satisfied with the surgical outcome? Yes No

Comments: _____

Assessing Doctor's Fax: _____ Would you like a reply: Yes No

Signature of Assessing Doctor: _____

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Surgeon Comments: _____

Gimbel Eye Centre Calgary Fax: (403) 202-3303 Gimbel Eye Centre Edmonton Fax: (780) 452-4114