Primary Eye Care Provider Refractive Surgery Follow Up Form

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

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

Assessing Doctor:_____ M OD M MD

Surgery Date:_____Type: M LASIK M PRK M ICL M SMILE M RLE M Cross Linking

EXAMINATION		**OD**		**OS**	
Visual Acuity Without Correction					
Manifest Refraction					
Keratometry					
Intraocular Pressure		mm Hg		mm Hg	Ocular Medications:
	Current				
LASIK/SMILE	Interface clear	M Yes	M No	M Yes	M No
	Flap smooth	M Yes	M No	M Yes	M No
	Flap in good condition	M Yes	M No	M Yes	M No
PRK	Haze Grading (please specify)	M Clear		M Clear	
		M Mild		M Mild	
		M Marked		M Marked	
RLE / ICL		M Yes	M No	M Yes	M No
	IOL/ICL centred	M Yes	M No	M Yes	M No
	Crystalline lens grading (ICL only)	M Yes	M No	M Yes	M No
	Periphery intact	M Yes	M No	M Yes	M 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? M Yes M No

Comments:_____

Assessing Doctor's Fax:_____Would you like a reply: M Yes M No

Signature of Assessing Doctor:_____

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Surgeon Comments:_____