GIMBEL EYE CENTRE

Primary Eye Care Provider Refractive Surgery Follow Up Form

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

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

Assessing Doctor: _____ ☐ OD ☐ MD

Surgery Date: _____Type: ☐ LASIK ☐ PRK ☐ ICL ☐ Cachet ☐ RLE ☐ Cross Linking

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

FOR GEC OFFICE USE ONLY

Surgeon Comments: _____

☐ Gimbel Eye Centre Calgary Fax: (403) 286-2943

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