

Questions? 877-508-2020

POST-OPERATIVE EXAMINATION

Renton / Spokane / Boise / Central Oregon / S. Portland

ID# _____

Patient Name: _____ DOB: _____ Exam Date: _____

Surgery Date: _____ Original Tx Enhancement LASIK PRK IntraLase CustomVue

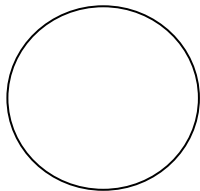
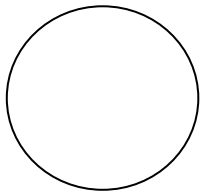
OD: 1 Day 1 Week 1 Month 3 Month 6 Month 1 Year Supplemental

OS: 1 Day 1 Week 1 Month 3 Month 6 Month 1 Year Supplemental

CC: _____ EYE MEDS: _____

_____ Dilation Time: _____ Cyclogel: 1% Tropicamide: 1% Phenyloph: 2.5%

OU 20/	OD UCVA: 20/ <input type="text"/>	OS UCVA: 20/ <input type="text"/>	IOP:
Manifest:	<input type="text"/> <input type="text"/> <input type="text"/> 20/ <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> 20/ <input type="text"/>	OD____ OS____
CycloPlegic:	<input type="text"/> <input type="text"/> <input type="text"/> 20/ <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> 20/ <input type="text"/>	Time: _____
Corneal Thickness:	Orbscan: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Ultrasound: _____	Orbscan: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Ultrasound: _____	
K Readings:	Max K Max Ax Min K Min Ax W2W _____ X _____ / _____ X _____	Max K Max Ax Min K Min Ax W2W _____ X _____ / _____ X _____	

<p>Slit Lamp Exam OD (if present, please grade)</p> <p>Subconjunctival Hemorrhage <input type="checkbox"/></p> <p>Epithelium Normal <input type="checkbox"/> SPK <input type="checkbox"/> Ingrowth <input type="checkbox"/> Defect <input type="checkbox"/></p> <p>Flap Normal <input type="checkbox"/> Edema <input type="checkbox"/> Microstriae <input type="checkbox"/> Folds <input type="checkbox"/></p> <p>Interface Normal <input type="checkbox"/> Debris <input type="checkbox"/> Diffuse Lamellar Keratitis <input type="checkbox"/></p> 	<p>Slit Lamp Exam OS (if present, please grade)</p> <p>Subconjunctival Hemorrhage <input type="checkbox"/></p> <p>Epithelium Normal <input type="checkbox"/> SPK <input type="checkbox"/> Ingrowth <input type="checkbox"/> Defect <input type="checkbox"/></p> <p>Flap Normal <input type="checkbox"/> Edema <input type="checkbox"/> Microstriae <input type="checkbox"/> Folds <input type="checkbox"/></p> <p>Interface Normal <input type="checkbox"/> Debris <input type="checkbox"/> Diffuse Lamellar Keratitis <input type="checkbox"/></p> 
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<p>Assessment:</p>	<p>Plan:</p> <p>Return: 1 2 3 4 5 6 <input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> months</p>
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Examined by:
(Co-managing doctor please provide Name, Address, Phone and Fax numbers)