# LASIK - Post-Procedure Care

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

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

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

## 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 6 7 Month: 1 2 3 or:

Patient Remarks:_____

MEDs:_____ QID TID BID QD Q2D Nil

MEDs:_____ QID TID BID QD Q2D Nil

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

Auto Refraction: _____

Manifest ( Wet / Dry ) :_____20/

*BIOMICROSCOPY:*

Adnexa: Normal Other:

Lids/Lashes: Normal Other:

Conjunctiva: Normal Other:

Tear Film: Normal Dry

Anterior Chamber: Deep Quiet Other:

IOP:_____@

*FLAP CONDITION:*

| | | | |
|---|---|---|---|
| **Position** | excellent | dislodged | striae |
| **Clarity** | clear | edema | haze |
| **Interface** | clear | opacities | epi ingrowth |
| **Edges** | smooth | rolled | eroded |

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

Treatment: _____

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

☐ Follow Up with GCEC ☐ Patient will Contact GCEC ☐ GCEC to contact pt.

GCEC Comments:

### LEFT EYE

Exam Date: Day: 1 2 3 4 5 6 7 Month: 1 2 3 or:

Patient Remarks: _____

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☐ Follow Up with GCEC ☐Patient will Contact GCEC ☐GCEC to contact Patient

**Doctor Signature:**_____ **Date:**_____

*Revised June 20209*

*GCEC is committed to providing the best care and results. Please fax to (727) 823-8796.*