

Gulfcoast Eye Care PRK - SURFACE ABLATION - Post-Procedure Care

Patient Name: _____ Patient's Birth Date: ____/____/____ Age: _____

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

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

RIGHT EYE

Procedure Information

LEFT EYE

PRK Date: _____ Aim: Distance Plano Monovision

PRK Date: _____ Aim: Distance Plano Monovision

Primary PRK Original RX: _____

Primary PRK Original RX: _____

Repeat PRK Enhancement RX: _____

Repeat PRK Enhancement RX: _____

RIGHT EYE

Post Operative Exam and Comments

LEFT EYE

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

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

Patient Remarks: _____

Patient Remarks: _____

MEDs: _____ QID TID BID QD Q2D Nil

MEDs: _____ QID TID BID QD Q2D Nil

MEDs: _____ QID TID BID QD Q2D Nil

MEDs: _____ QID TID BID QD Q2D Nil

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

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

Auto Refraction: _____

Auto Refraction: _____

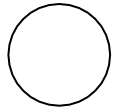
Manifest (Wet / Dry): _____ 20/

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CORNEAL CLARITY:

HAZE GRADE

HAZE PATTERN



- Clear
- Trace Reticular
- Mild Reticular
- Moderate Confluent
- Severe Confluent

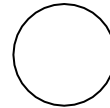
- Diffuse
- Focal
- Arcuate

IOP: _____ @

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HAZE GRADE

HAZE PATTERN



- Clear
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- Diffuse
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IOP: _____ @

Doctor's Impression: Excellent Stable Enhancement Other:

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Treatment: _____

Treatment: _____

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

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

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Comments:

Doctor Signature:

Date: