Lasik Post-Op Evaluation

Referring Doctor:____________________

Please FAX completed form to:
Parker: 720.880.6460
Boulder: 303.593.2199

Name (First/Last):	Age:	Surgery Date:	Primary Enhancement

Exam Data

		OD			OS		
	Goal:				Goal:		
1 Day 10 Day 2 Mo Other: ______	History	Happy	Unsure	Unhappy	Happy	Unsure	Unhappy
	Meds			AT's ____ x a day			AT's _____ x a day
	Acuity	UCVA 20/			UCVA 20/		UCVA OU 20/
	Refraction			20/			20/
	Flap	Good SPK Debris Straie DLK EI Other: ________			Good SPK Debris Straie DLK EI Other: ________		
	Assessment	Good	Unsure	Enhance	Good	Unsure	Enhance
	Plan	RTC		InS CoMg	RTC		InS CoMg

Notes:

Today's Date ______________________ Doctor's Signature

Exam Data

		OD			OS		
1 Day 10 Day 2 Mo Other: ______	History	Happy	Unsure	Unhappy	Happy	Unsure	Unhappy
	Meds			AT's ____ x a day			AT's _____ x a day
	Acuity	UCVA 20/			UCVA 20/		UCVA OU 20/
	Refraction			20/			20/
	Flap	Good SPK Debris Straie DLK EI Other: ________			Good SPK Debris Straie DLK EI Other: ________		
	Assessment	Good	Unsure	Enhance	Good	Unsure	Enhance
	Plan	RTC		InS CoMg	RTC		InS CoMg

Notes

Today's Date ______________________ Doctor's Signature