MONSON VISION

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POST- PROCEDURE REPORT

Patient: _____ **Date:** _____

Procedure: OD LASIK PRK SMILE Kamra RLE Date: _____ Referring Doctor _____

OS LASIK PRK SMILE Kamra RLE Date:

Post Op Day: OD _____ OS _____ OS _____

CC: _____

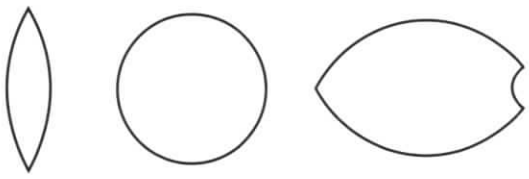
_____

Meds: OD _____ OS _____

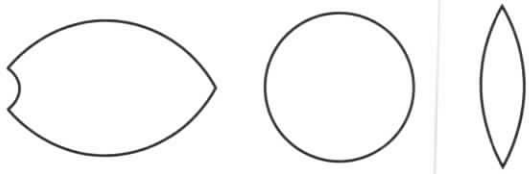
	SPH	CYL	AXIS	ADD	Vcc	Vcc OU	Vsc	Vsc OU	Vsc Near	Vcc Near			
DRY					20/	20/	20/	20/	J	J	T	OD:	OS:
					20/		20/		J	J		Time:	
CYCLO				20/	TOPO	OD Reg Asym Irr Other: _____							
				20/		OS Reg Asym Irr Other: _____							

Slit Lamp Examination:(Please draw flaps for LASIK)

☐ **OD** – Except as noted, corneal epithelium, interface, and associated tissue signs are normal or as expected



☐ **OS** – Except as noted, corneal epithelium, interface, and associated tissue signs are normal or as expected



A ☐ Normal post-operative result, except as noted:

_____

_____

P ☐ Continue post-operative treatment

_____

_____

Reviewed Post-Procedure Instruction: Yes No

Reviewed Meds: Yes No

RTC: _____

Dr. _____
(signed)

Please send to Monson Vision at ashley@monsonvision.com or 435.787.7203 (F)

☐ **Faxed** ☐ **Emailed MV on (*date*)_____ by (*init.*)_____**